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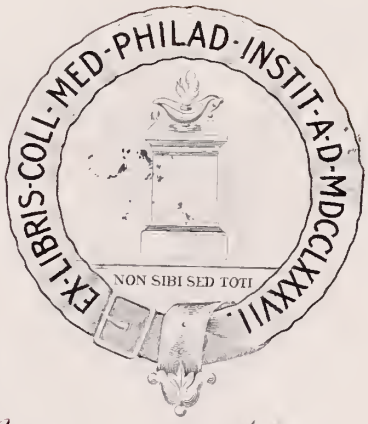

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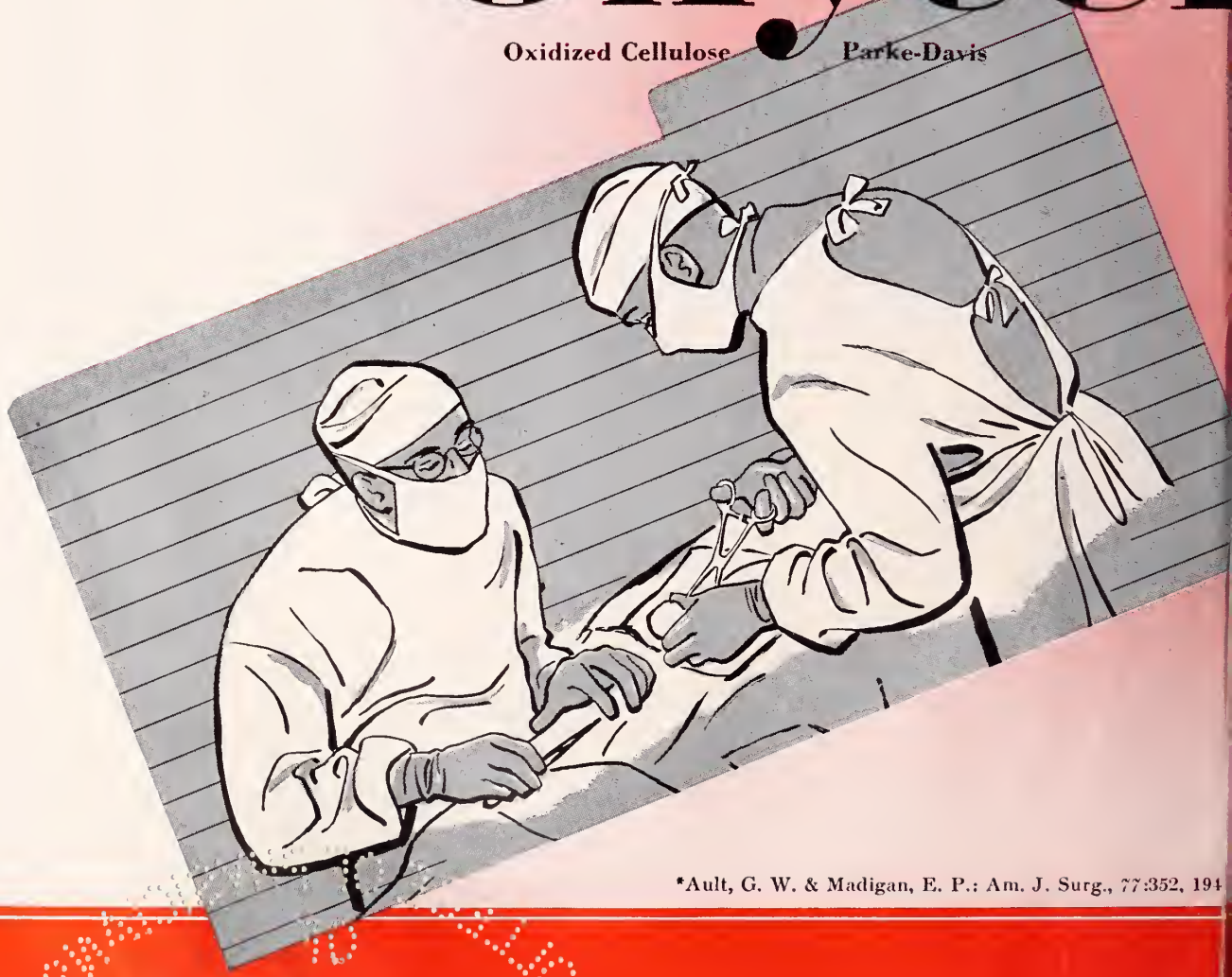

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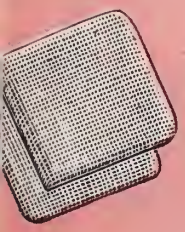

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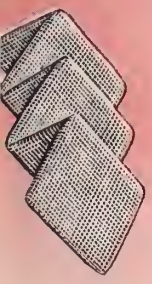

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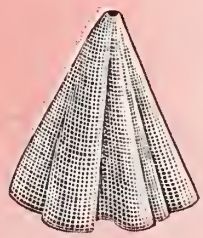

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MADISON, WISCONSIN, JANUARY, 1950

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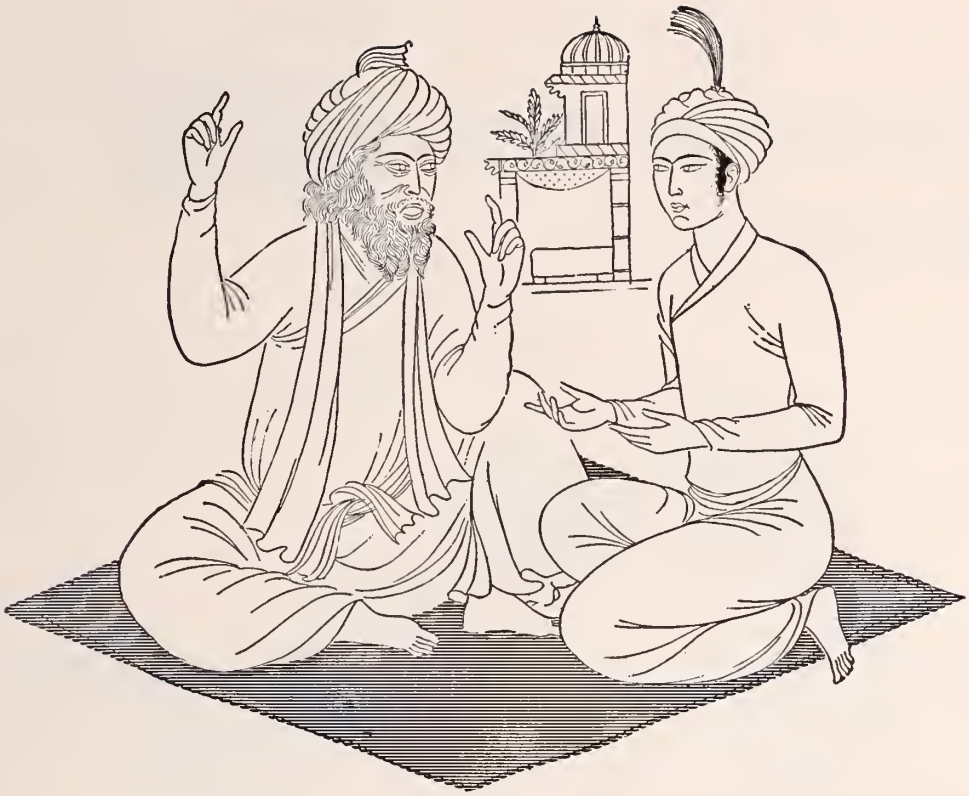

In the City of Baqdad lived Hakeem, the Wise One, and many people went to him for counsel, which he gave freely to all, asking nothing in return.

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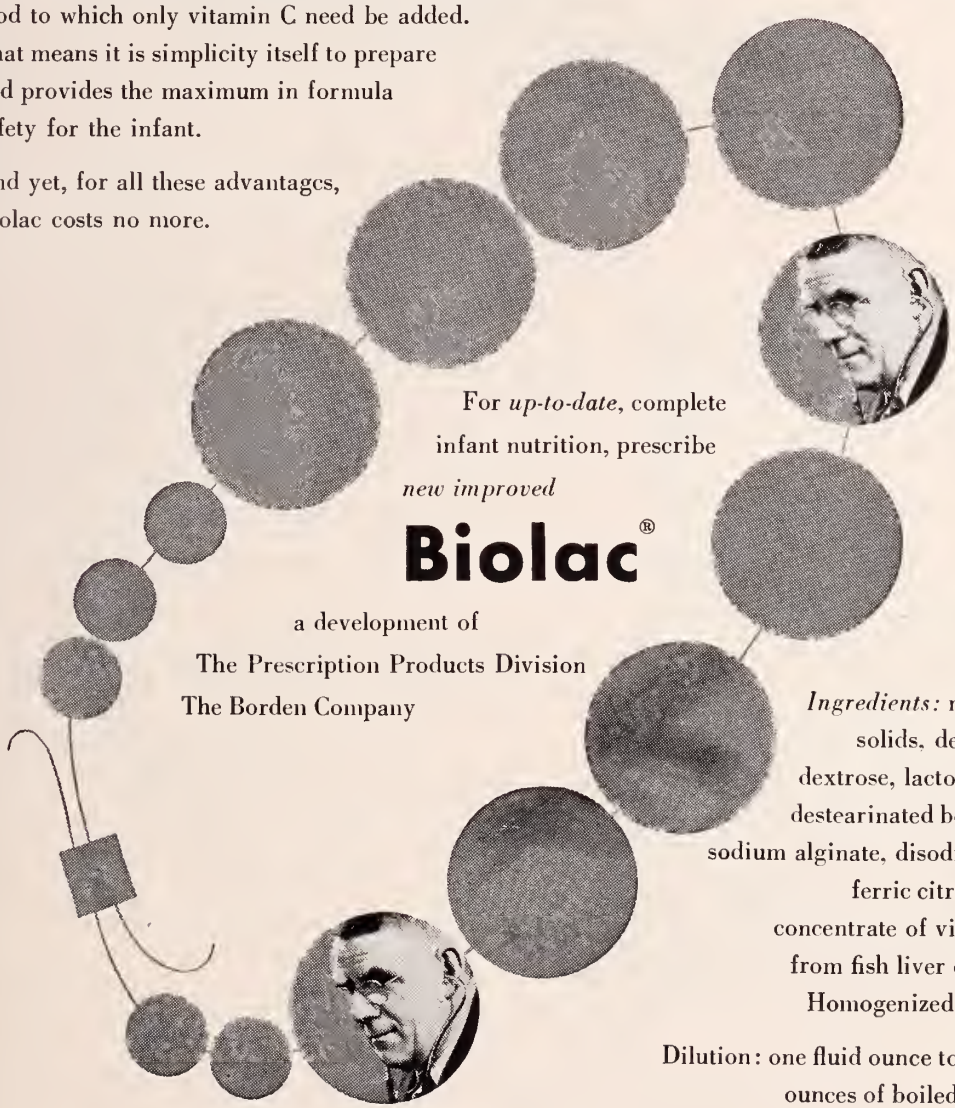

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« « « EDITORIALS » » »

A Stride Forward in Mental Hygiene

IN AND out of government circles, by professional men and laymen, by the reformer and the non-reformer, for many years better medical care in state institutions for the mentally ill has been a current topic of discussion. For as many years it has been recognized by informed medical practitioners and teachers that prerequisite to this accomplishment is the elevation of the medical personnel in these hospitals to the intellectual quality and attained skill of good teachers, and the increase of their members to adequacy for good medical practice.

One way of attaining this goal that has been suggested through the years is the development of teaching centers in these hospitals. This project has never gone beyond palaver. No way was found to induce the desired quality of professional men in adequate numbers into the state service through the methods of civil service and under the existing salary scales.

The authorities in the University of Wisconsin Medical School have been sympathetic with and agreeable to these ideas and ideals and also with the need for the teaching facility, but no clear method for their accomplishment has been proposed that would protect the standards required by the University faculty and at the same time conform to the legal requirements for employing personnel under the civil service law.

After these years of discussion and agreement among those in the know, it appears that we now have the "know-how". The last legislature removed the salary limitation and provided adequate money for attractive salary scales. With this obstacle removed, the governor asked the dean of the University of Wisconsin Medical School to give thought to and propose a plan whereby a joint participation of the medical school and other divisions of the state government might be mutually helpful in attracting into state service the needed professional personnel. This resulted in a proposed integration of postgraduate training for psychiatrists in the medical school with teaching centers to be set up in the state hospitals for the mentally ill.

The success of this proposal depends upon the selection by the Board of Public Welfare of a director for the Division of Mental Hygiene who has the training, experience, and demonstrated skill required by the medical school faculty for the academic status of professor. To assist the Board of Public Welfare in the selection of a qualified person, the dean of the medical school has submitted a plan for the integration of the graduate teaching in the medical school and that in the proposed centers to be developed in the hospitals at Mendota and Winnebago and for undergraduate teaching.

The plan shows the Department of Neuropsychiatry as it now exists in the University. The Bradley Memorial Hospital is the center of activity for this department, the staff of which are consultants to all other faculty members in other divisions and departments of the medical school, and the State of Wisconsin General Hospital.

Outside of the medical school's jurisdiction there is the Division of Mental Hygiene of the Department of Public Welfare, and it is integrated with the Psychiatric Institute in the medical school. This is accomplished through the director of the Division of Mental Hygiene and his position on the staff of the Psychiatric Institute.

To hook up these two groups it is agreed that the director of the Mental Hygiene Division of the Board be appointed to a professorship of psychiatry on the staff of the Psychiatric Institute.

To insure to the university the selection of a psychiatrist who will fulfill its requirements it is agreed that the dean of the medical school recommend to the Board of Public Welfare a qualified psychiatrist for the directorship of the Division of Mental Hygiene; one whom he will accept and appoint to a professorship in psychiatry on the faculty of the medical school.

In the beginning, when the director will be giving so much of his time to organization and other duties in connection with his function as director of the Division of Mental Hygiene in the Department of Public Welfare, it is agreed that the entire salary of the director shall be paid out of funds provided to the Department of Public Welfare which in accordance with the expressed wish of the legislature in its last session may be a maximum of $12,000 if necessary to obtain the proper person.

To insure to the Board of Public Welfare an avenue for ready consultation with the University authorities and to preserve the responsibilities of the Board in the field of mental hygiene and the care of the mentally ill patients, it is suggested:

That a committee composed of the dean of the University of Wisconsin Medical School, the director of the Department of Public Welfare, and a member selected by the Board from the members of the Board of Public Welfare be approved by the University Board of Regents and by the Board of Public Welfare;

That the function of the committee be that of maintaining a close relation between the Medical School and the Board of Public Welfare in their planning for the training of residents in psychiatry and other postgraduate teaching, for the preservation of good medical care and treatment for mentally ill patients in Mendota and Winnebago and county hospitals, and in planning for the promotion and preservation of mental health throughout the state.

The committee is vested with no power of policy determination or any other of the responsibilities, legal or otherwise, which come under the powers and duties of the Board of Public Welfare or the Board of Regents of the University.

The acceptance by the Board of the proposals suggested in this report constitutes a great stride towards the goals for which others have been striving—if not striving, certainly pointing to—for many years. The Diagnostic Center for which the legislature in the 1943 session appropriated $600,000 for a building to be located on property adjacent to the Wisconsin General Hospital and the staff of which was to be appointed by the dean of the Medical School from the teaching staff of the school is a part of and intimately tied to the developments which these proposals open up.

In conjunction with these developments it is planned to develop beds for diagnostic problems in children and other patients and an outpatient clinic service in the Neuropsychiatric Institute in the medical school.

A Word of Explanation

This issue of the Journal is sent as the 1950 supplement to the Wisconsin Medical Blue Book, and brings up to date the information contained in last year's January number. There are also a number of new articles relating to laws and regulations affecting the medical profession in Wisconsin.

The Journal is punched in order that it may be kept in a single ring book with the Wisconsin Medical Blue Book, for handy reference. A limited supply of ring books is now available at cost price ($1.00), and may be ordered from the State Medical Society, 704 East Gorham Street, Madison 3, Wisconsin.

. . . . THE PRESIDENT'S PAGE . . . .

Service Is the Best Answer

EVERY county or city has real emergency cases. Night calls are routine with almost every practicing physician. Yet one of the weak spots in medical organization is the occasional inability to put physicians in immediate contact with such cases. A single instance of undue delay in getting the doctor to the accident scene, or one unanswered call for night service, is enough to bring sharp criticism from the public. Right or wrong, the public expects twenty-four-hour-a-day medical service.

The first requisite to successful handling of night and emergency calls is an understanding and willing medical profession. Some physician has to make the emergency night call; every physician should do his part so that the burden does not fall on the few. The physician who accepts a fee for service rendered during the day morally obligates himself to see that the patient receives medical attention at night, and the patient who does not have a family physician is entitled to emergency care. Incidentally, what is a better way to become a family physician than to follow such a code? It is gratifying to know that individual physicians all over the state are making, as they always have, a sincere and determined effort to provide service whenever it is needed regardless of circumstances.

The second requisite is a plan for handling such calls that is understood and accepted by the public and the physicians. One can sympathize with the small town Wisconsin doctor who said he makes over 700 night calls each year—an average of two per night. At River Falls, the doctors have found the answer to this problem by means of a telephone arrangement with the local hospital which calls doctors on a panel basis. Doctors at Antigo, Beloit, Janesville, Fort Atkinson, Fond du Lac, Marshfield, and other cities have started and publicized similar plans. Milwaukee's elaborate service bureau has a national reputation. Do the people of your community clearly understand how they can reach a physician for a night emergency?

From many parts of the country, reports are coming into American Medical Association headquarters that county medical societies are setting up night and emergency call systems. A recent American Medical Association publication for use of county medical society officers outlines in detail the plans used by sixteen county societies to handle this problem. These plans should effectively stop a major source of complaints—if the public and the doctors are educated to use the service.

The public itself has to assume a burden of responsibility for an effective answer to this problem. Any physician with experience in the actual practice of medicine knows the problems caused by the hypochondriac—the person who waits until midnight to say "Doctor, I feel awful," and then expects the physician to travel five miles to deliver an aspirin.

There is little justification for complaint, however, from persons who have lived in a community for years without having contacted a physician in anticipation of emergency night medical attention. Telephone answering services won't work when patients fail to call the "If no answer" directory number. And physicians are rightly angered when frantic calling by one or more persons at an accident scene brings several physicians where only one is needed. These problems indicate the extent to which a patient is responsible for his own care in emergencies.

Successful solution of the night call and emergency call situation depends in large measure upon double-edged promotion—some directed to the public, some to doctor members of the society. This has been done by the Council on Medical Service and Public Relations. More needs to be done. Yet in the final analysis, a curt "I don't make night calls" from the individual physician is the best possible argument for those who wish to fasten on the profession full responsibility for lack of adequate medical care. Each county medical society would be wise to make known to the public a central telephone number at which will be maintained a panel of physicians who are willing to make night and emergency calls. Regardless of method, the physician's best answer to criticism on this problem is prompt and efficient service.

John Wm Truitt MD

Fee Schedules and the Sherman Antitrust Act*

PRICE fixing, as it relates to commodities and articles of trade, has been declared by the United States Supreme Court to be an unreasonable restraint of trade and illegal within the meaning of the Sherman Antitrust Act. In a recent case decided by the district court for the District of Columbia the government contended for the first time that the adoption of fee schedules applicable to the delivery of personal services is likewise proscribed by the federal law. The Washington Real Estate Board had for many years, as had other associations of brokers, prescribed rates of commissions for brokers' services, and prior to this case the government had never centended that such activity violated the Sherman Antitrust Act. The Washington Board and its individual members, however, were alleged to have "combined to fix real estate brokerage commissions" in an unlawful manner. The National Association of Real Estate Boards was also named a defendant in the case for having allegedly "encouraged" and "incited" the local organization to act as it did. This was not a clandestine or surreptitious activity of the Washington Board, and the rates were generally adhered to by members and nonmembers in the Washington area. In denying the government's request for an injunction, the trial judge said:

> A real estate board may in a sense be likened to a labor union of real estate brokers. Admittedly there is no case in the Federal courts that has applied to personal services the rule that the fixing of prices of commodities or articles is *per se* an unreasonable restraint of trade. To contract for one's personal services is a fundamental right of every man. For men to combine to regulate the compensation to be charged by them for their own services is also entirely legal. While this right has been generally recognized in respect to persons who toil for wages or salaries, no reason appears discernible why it is not equally applicable in principle to those persons who work for commissions. The instant case appears to be the first occasion in the history of the enforcement of the Sherman Act that the Government has challenged this right.

As a matter of fact, the result of the stabilization of charges and the consequent uniformity has generally been considered as being in the public interest, although the court conceded that a different problem might be presented if the rates fixed were shown to be unreasonable.

The similarity between the fixing of brokers' commissions by brokers' organizations and acceptance of fee schedules by medical societies and bar associations is, of course, readily apparent. Government itself has encouraged, and even required, the adoption of physicians' fee schedules. Examples of this activity at the federal level are the Veterans Administration medical care program and some of the activities of the Children's Bureau. At the state level workmen's compensation laws have necessitated the fixing of fees for medical services. At the local level fee schedules applicable to welfare patients are not uncommon.

If the court had upheld the government's contention that the adoption of fee schedules is contrary to the Sherman Antitrust Act, the government itself could be shown to be one of the worst offenders. Fortunately, the decision of the court has thwarted another unreasonable attempt by government to extend its control over private enterprise.

* Reprinted, with permission, from the Journal of the American Medical Association, November 19, 1949.

IDENTIFICATION BY BLOOD TEST

Whenever relevant to the prosecution by the mother, or defense by the alleged father, in an illegitimacy action, the trial court may order the mother, child and alleged father to submit to one or more blood tests to determine whether the defendant can be excluded as the father of the child. The results of the test are admissible only to prove that the defendant is not the father; the results of a test which show only that the defendant might be the father are not admissible. Such tests are conducted by a physician or physicians, licensed to practice medicine and surgery, or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county. Sec. 166.105, statutes.

Whenever relevant in a civil action to determine the parentage or identity of any child, person or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are its results receivable in evidence. Sec. 325.23, statutes.

The Privileged Status of Communication Between A Patient and His Physician Again Limited

THE Wisconsin Supreme Court has again considered what constitutes a privileged communication between a patient and his physician. In the case of *Leusink v. O'Donnell et al.* 39 N. W. 2d. 675, decided on November 15, 1949, the Court indicated that it would probably consider as privileged only such disclosures made by a patient to his physician which would *subject the patient to shame or affect his reputation or social standing* were the physician to release that information. Because the Court's opinion in the *Leusink* case reviews the privilege question as it has ben developed by court decision in Wisconsin, the relevant portions of it are quoted in full.

An action was commenced in the Circuit Court for Rock County by Leusink against O'Donnell and his insurance company to recover for personal injuries sustained by Leusink in an automobile accident. The defendants applied to the court for an order author-
reports. The Circuit Court denied the application,
reports. The Circuit Court denied the application, and the defendants appealed to the Wisconsin Supreme Court. The court stated that:

> "The petition in support of the motion for the order contained the following allegations: . . . that defendants requested the attorneys for the plaintiff to make available to them the findings of the medical examination of the plaintiff by Dr. Rentz in June, 1947; that plaintiff's attorneys failed to provide defendants with the medical records requested; that one of the issues that will arise at the trial of said action will be the nature and extent of the disability of the plaintiff existing prior to the automobile accident; that the defendants cannot proceed safely to trial without an inspection of said medical records compiled at the Monroe clinic, Monroe, Wisconsin, during June, 1947, upon the consultation by the plaintiff with Dr. Rentz and any other physicians concerned, and the medical records compiled at the Veterans Administration Hospital at Wood, Wisconsin, during December, 1946; such medical records were described as follows: (1) hospital records; (2) nurses notes and records; (3) technician's notes and records; (4) medical reports of attending physicians; (5) other medical information of a documentary nature concerning the plaintiff; and that the above-described records and documents are in the control of the plaintiff herein. . . .
>
> "(2, 3) The plaintiff contends that these records are privileged under sec. 325.21, Stats. This court has indicated in prior decisions that this statute is to be strictly construed. In Prudential Insurance Co. v. Kozlowski, 226 Wis. 641, 276 N. W. 300, 301, it was held that the following evidence is admissible: (1) the testimony of the nurse who assisted the physician in the treatment of the insured; (2) the record made by the nurse upon the insured's admission to the hospital and during his treatment therein which was used by the physician in treating the patient; (3) the testimony of an x-ray operator employed by the hospital; and (4) an x-ray plate made by this operator at the direction of the attending physician. Following the rule laid down in that case it is apparent that the hospital records, nurses' notes and records, and the technician's notes and records sought by the defendants are not privileged. If the privilege applies at all it would be to the medical reports of the attending physicians and other medical information of a documentary nature if made by an attending physician. The rule in this state under said privilege statute is stated in Prudential Insurance Co. v. Kozlowski, supra, as follows: 'The reason of the rule of the statute, as far as it has any, is that patients may be afflicted with diseases or have vicious or uncleanly habits necessary for a physician to know in order to treat them properly, disclosure of which would subject them to humiliation, shame, or disgrace, and which they might refrain from disclosing to a physician if the physician could be compelled to disclose them on the witness stand. Boyle v. Northwestern Mutual Relief Ass'n, 95 Wis. 312, 70 N. W. 351. If the disclosures to the physician be such as not to subject the patient to shame or affect his reputation or social standing, there is no reason why a physician should not disclose them, and sound reason why in the interest of truth and justice he should be compelled to disclose them. The physician's exemption from disclosure should in reason be limited to such disclosures as would injure the patient's feelings or reputation. The statute too often works, as stated by Mr. Justice Owen in his dissenting opinion in Maine v. Maryland Casualty Co., 172 Wis. 350, 359, 178 N. W. 749, 752, 15 A. L. R. 1536, to cheat rather than to promote justice and to suppress rather than reveal truth.* * *' "

Harrison Narcotic Act and Prescriptions*

THE Harrison Narcotic Act is intended to control narcotic drugs so that they are used only for medical purposes. This law prohibits a pharmacist from filling an oral prescription; a written prescription must be received before the drug can be dispensed. A pharmacist can deliver narcotic drugs following a telephone order only when a genuine emergency exists. A physician cannot use his prescription form to obtain narcotic drugs for general office practice. Narcotic drugs for such use must be obtained on an official order from a qualified manufacturer or wholesale dealer. A prescription for a narcotic drug must be dated and signed on the date when issued, and it must bear the full name and address of the patient and the name, address and registry number of the practitioner. Such prescriptions must be typed or written in ink or indelible pencil. If typewritten the prescription must be signed by the practitioner. Prescriptions for narcotic drugs cannot be refilled. Narcotic prescriptions can be used only for legitimate medical purposes, responsibility for proper prescribing resting essentially with the practitioner. Narcotic prescriptions cannot be issued to addicts or habitual users of narcotics.

Prescriptions Under the Federal Food, Drug and Cosmetic Act*

IN MORE recent years there have been developed laws that affect the prescribing and dispensing habits of physicians and pharmacists. In earlier years, with the exception of narcotics, the majority of drugs that were used by physicians were not subject to many restrictions, and it was customary to regard with considerable leniency oral prescriptions for drugs and refilling of written prescriptions without specific authorization. During the past few years state laws have been developed which prohibit the issuance of certain drugs without prescription. A local law exists in New York City. In addition, however, there is the Federal Food, Drug and Cosmetic Act, the provisions of which are not yet familiar to all members of the medical profession, but which, nevertheless, are intimately concerned with the use of drugs. Furthermore, new interpretations are being placed on these provisions, so that it is necessary for members of the medical profession to be fully aware of current restrictions on prescribing and dispensing habits if they wish to avoid or refrain from encouraging violations of this federal law.

While the Federal Food, Drug and Cosmetic Act has been regarded by many who are not familiar with its provisions as being concerned essentially with questions of accurate labeling, prevention of adulteration and safety its provisions, on the basis of recent court decisions and interpretations of the Food and Drug Administration, go beyond such concepts. Among the restrictions placed on prescribing and dispensing habits are several concerned with so-called prescription items and refills. The physician must have a proper understanding of these restrictions if he is to prevent misunderstanding and perhaps even embarrassment for himself or for his patients and the pharmacists who fill his prescriptions. Under the act a prescription is generally regarded as a written order by the physician for a specific quantity of drug to meet a patient's specific needs. A prescription, then, cannot be refilled, according to current interpretation of the Federal Food, Drug and Cosmetic Act, without specific authorization of a physician. To refill the prescription without authorization is, in the eyes of the Administration, equivalent to an over-the-counter sale. Over-the-counter sale of drugs that are prescription items is prohibited by law, and pharmacists are not permitted to dispense prescription items without a prescription or to refill such prescriptions without specific authorization. This means that the physician must authorize as many refills as he believes are necessary for the patient for whom the prescription is intended at the time he writes the prescription. If such authorization is missing from the original prescription the pharmacist, according to the administration, must assume that the physician intended the prescription be filled only once. The physician, of course, can issue instructions later for refills if such action seems indicated. These later instructions to the pharmacist may be verbal or written, but they must be issued directly to the pharmacist and not indirectly through the patient.

Prescription drugs are those which carry on the label a statement such as "Caution: To be dispensed only by or on the prescription of a physician" (or dentist or veterinarian). If such a legend is not present on the label, then the item presumably is a so-called non-Rx legend drug, in which case the labeling must bear adequate directions for use—which means for self medication. If a drug bears an Rx legend it cannot be sold without a prescription.

* Reprinted, with permission, from the Journal of the American Medical Association, August 6, 1949.

At times pharmacists must place on a prescription label certain warnings; for example, "Warning: May be habit forming." This is done if the drug is a narcotic or hypnotic substance named in a certain section of the Federal Food, Drug and Cosmetic Act if (*a*) the doctor does not mark the prescription order as not refillable or (*b*) refilling is not prohibited by local law. If the physician specifies in the prescription order that it may be refilled a certain number of times at stated intervals, and that it is not refillable after the last filling, none of the dispensed material is required to bear the warning label.

Another warning that occasionally must be placed on the prescription label by the pharmacist is one associated with certain potent drugs. So far, the Food and Drug Administration has decided that thiouracil, prophylthiouracil and pentaquine must bear a warning because of the possibility of untoward reactions from the use of these drugs. This warning reads: "Warning: This drug may cause unfavorable reactions in some individuals. Your physician has explained or will explain to you the symptoms that must be watched for and precautions that must be taken to guard against ill effects. Do not take in larger doses, or for a longer time than specifically directed by the physician."

Physicians who dispense as a bona fide part of their professional practice and who by oral statements impress on the patient adequate directions for use and warnings about probable unfavorable reactions are not subject to the labeling requirements of the law that apply to pharmacists in filling prescriptions. Nevertheless, it would be in the interest of safety for such a physician to supplement his oral directions and warnings with label notations on the dispensed package.

Physicians whose dispensing is not a bona fide part of their professional practice are, of course, subject to the same requirements that apply to pharmacists.

The Food and Drug Administration does not issue an official list of drugs which may be sold only on prescriptions. However, any item that bears the prescription legend is limited to issuance by prescription, and a prescription for such an item must be written, as oral prescriptions can be recognized by a pharmacist only in times of emergency.

New Wisconsin Laws

MORE than 150 proposals involving the public health were considered during the 1949 session of the Wisconsin legislature. Of particular interest, are those which received favorable legislative action and are now the law of the state.

Use of Animals For Medical and Scientific Research

After numerous debates and public hearings, the 1949 legislature declared that "the public health and welfare of this state . . . is protected and promoted by permitting the humane use of animals for diagnosis and treatment, thereby aiding in the advancement of veterinary, dental, medical and biological sciences, and in the testing, improvement and standardization of laboratory specimens, biological products, pharmaceuticals and drugs."

It then passed a bill assuring an adequate supply of dogs for the state's institutions of higher learning. Under the new law, those institutions may requisition unclaimed or unredeemed dogs from any pound or officer having custody of such dogs. Safeguards in the bill assure dog owners that they have a reasonable period of time in which to claim a lost dog before it may be released to an educational institution.

Postmortem Examination

A great deal of confusion has always existed about whose consent is required to permit a physician to conduct a postmortem examination with impunity. Sometimes the next of kin was not immediately available, or there were several persons of the same degree of kinship. The physician who performed such an examination without proper written consent did so at considerable personal risk.

Under the new law, consent for a physician to conduct a postmortem examination is sufficient when given by the person who assumes custody of the body for burial, providing he is the father, mother, husband, wife, child, guardian, or next of kin. If none of these are available, consent may be given by a friend or person charged by law with responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

New State Board of Nursing

The 1949 legislature dissolved the committee on nursing education of the State Board of Health and created a new and separate State Board of Nursing. The law gives recognition to trained practical nurses and requires that registered nurses and trained practical nurses be examined by separately appointed boards. The law was the result of a special study of the State Board of Health conducted by the State Medical Society at the request of the Legislative Council.

Osteopathic Licensure

Students graduating from osteopathic colleges are permitted by 1949 law to take the same examination in all subjects as given graduates from medical schools and to be granted licenses to practice medicine and surgery, provided the State Board of Medi-

cal Examiners finds that the student's college of graduation maintains standards of education and training substantially equivalent to those of the University of Wisconsin Medical School.

The law also permits present osteopathic licentiates to take a refresher course of 124 hours in an osteopathic college approved by the State Board of Medical Examiners. Favorable completion of such a course entitles the osteopath to take the same examination in materia medica and pharmacology as given medical graduates. Upon successful completion of the examination, the osteopath will be granted a new license to practice medicine and surgery upon the surrender of his former osteopathic license.

Practice of Chiropody Defined

The practice of chiropody was limited by the 1949 legislature to the diagnosis or mechanical or surgical treatment, or treatment by the local application of drugs, of the feet. It does not include amputations or surgical operations upon the feet for congenital or acquired deformities or conditions requiring the use of an anesthetic other than local, nor treatment of any portion or organ of the body above the feet, except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg in so far only as they shall be involved in the conditions of the feet.

A chiropodist may not perform major surgical operations upon the foot, nor minor operations upon the foot involving vascular diseases or diabetes except upon the advice of a licensed physician. Neither may he treat conditions of the feet involving osteomyelitis, malignancies, or syphilis. Also prohibited is the therapeutic use of x-ray and radium, and cutting operations involving the bones, ligaments, muscles, nerves, or tendons of the feet.

State Laboratory of Hygiene Appropriation

For many years the State Laboratory of Hygiene, under the direction Dr. W. D. Stovall, has operated without an adequate physical plant. These inadequacies forced it to turn down many requests for water testing, cancer recognition, pollution investigation and consideration of industrial hazards. Previous requests for funds were unsuccessful, but the 1949 legislature appropriated $750,000 which will be coupled with $613,636 in federal aid for the construction of a new and separate laboratory on the University of Wisconsin campus.

Direct Payment of Insurance Benefits to Physicians

Private insurance companies writing a group policy containing benefits for hospital, medical or surgical expenses may now pay such benefits directly to the physician, hospital or other person or institution furnishing the services covered by the policy. Prior to passage of this law in 1949, insurance companies offering this type of contract were required to make direct payment to the insured.

TAX DEDUCTIONS FOR HEALTH EXPENSES

Following is a summary of the principal provisions of the state and federal income tax laws relating to the deductibility of health expenses of the tax payer and his immediate family.

1. *Federal Law.* Among the items deductible are medical, dental, drug, nursing, hospital, x-rays, premiums for health and accident insurance, travel directly related to hospitalization, including, in the case of a helpless patient the travel expenses of a parent or another companion. To be deductible, *such expenses must be actually paid*, not merely incurred during the tax year.

Only those health expenses in excess of 5 per cent of the tax payer's adjusted gross income may be deducted. Such expenses are *not* allowable up to an amount equal to 5 per cent of such adjusted gross income. For maximum health deductions and fuller treatment of this subject in the federal statute see the *Wisconsin Medical Journal*, December 1949, page 1095.

2. *Wisconsin Law.* Medical, surgical, dental, hospital, nursing, and other healing services and the cost of drugs and medical supplies incurred by the tax payer on account of sickness or of personal injury to himself or his dependents as well as premiums for health and accident insurance are deductible *if paid* during the tax year, for total amounts in excess of $50.00, but not exceeding $500.00. In other words, the first $50.00 of health expenses of a Wisconsin income tax payer and his dependents is not allowable, nor is any excess of such expenses over $500.00. This point is also to be found in the income tax article in the *Wisconsin Medical Journal*, December 1949, page 1101.

State Board of Health Services and Communicable Disease Rules

State Board of Health

Members of the Board

Stephen E. Gavin, M. D., President, Fond du Lac, 1950
Samuel L. Henke, M. D., Vice-President, Eau Claire, 1953
Carl N. Neupert, M. D., Secretary and State Health Officer, Madison, ex officio
William T. Clark, M. D., Janesville, 1956
Gunnar Gundersen, M. D., La Crosse, 1951
Carl D. Neidhold, Appleton, 1952
Forrester Raine, M. D., Milwaukee, 1954
Stephen Cahana, M. D., Milwaukee, 1955

Bureaus, Divisions, and Units of State Board of Health

GENERAL ADMINISTRATION

Carl N. Neupert, M. D., State Health Officer
E. H. Jorris, M. D., Assistant State Health Officer

C. N. NEUPERT

E. H. JORRIS

Bureau, Division or Unit

Division of Personnel—Henry Kjentvet, B. S., Director
Division of Budgets & Accounts—Fred E. Brown, C. P. A., Director
Division of Laboratories—W. D. Stovall, M. D., Director
Bureau of Vital Statistics—Paul Weis, Assistant State Registrar
Microfilm Laboratory—William Dewey, Supervisor
Division of Dental Education—Francis A. Bull, D. D. S., Supervisor
Division of Health Education—Ralph Kuhli, M. P. H., Director
Division of Hospital Survey & Construction—Vincent F. Otis, Director
Division of Statistical Services—Vivian B. Holland, MSPH, Statistician
Division of Cosmetology—Lenore Brandon, Acting Supervisor
Division of Barbering—Charles E. Mullen, Supervisor
Division of Funeral Directing & Embalming—Helen Kjelson, Adm. Assistant

Section on Preventable Diseases

ARTHUR R. ZINTEK

Arthur R. Zintek, M. D., Director
Bureau of Communicable Diseases—Arthur R. Zintek, M. D., Acting Director
Bureau of Tuberculosis Control — Arthur R. Zintek, M. D., Acting Director
Wis. State Sanatorium — Richard H. Schmidt, Jr., M. D., Superintendent
Lake Tomahawk State Camp—Sigmund Rulland, Superintendent
Division of Venereal Disease Control—A. L. Van Duser, M. D., Director
Division of Cancer Control—A. L. Van Duser, M. D., Director
Division of Heart Disease Control—Arthur R. Zintek, M. D., Acting Director

Section on Environmental Sanitation

O. J. MUEGGE

O. J. Muegge — State Sanitary Engineer
Division of Plumbing—Walter Spencer, Supervisor
Division of Well Drilling, (Vacancy)
Slaughterhouses—E. J. Tully, Supervisor
Rendering Plants — E. J. Tully, Supervisor
Water Pollution—T. F. Wisniewski, Sanitary Engineer
Milk Sanitation—C. K. Luchterhand, Sanitarian

Section on Maternal and Child Health

AMY LOUISE HUNTER

Amy Louise Hunter, M. D., Director

Bureau of Maternal and Child Health—Amy Louise Hunter, M. D., Chief

Division of Mental Health — Eugenia S. Cameron, M. D., Director

Nutrition — Lucile K. Billington, M. S., Supervisor

School Health Education—Catherine K. Campbell, Ph. M., Educator

Section on Local Health Administration

ALLAN FILEK

Allan Filek, M. D., Director

Division of Local Health Administration—Allan Filek, M. D., Director

District Health Offices

No. 1—Beaver Building, Madison

Health Officer: Dr. Pierce D. Nelson

Counties included: Crawford, Richland, Sauk, Columbia, Dane, Green, Lafayette, Iowa and Grant

No. 2—Municipal Building, Elkhorn

Health Officer: Dr. Elmer E. Bertolaet

Counties included: Jefferson, Rock, Waukesha, Walworth, Milwaukee, Kenosha and Racine

No. 3—Court House, Fond du Lac

Health Officer: (Vacancy)

Counties included: Winnebago, Sheboygan, Calumet, Dodge, Manitowoc, Washington, Fond du Lac and Ozaukee

No. 4—City Hall, Sparta

Health Officer: (Vacancy)

Counties included: La Crosse, Waushara, Green Lake, Monroe, Juneau, Vernon, Adams and Marquette

No. 5—City Hall, Wisconsin Rapids

Health Officer: (Vacancy)

Counties included: Pepin, Clark, Buffalo, Wood, Trempealeau, Marathon, Jackson and Portage

No. 6—City Hall Annex, Green Bay

Health Officer: Dr. Milton Feig

Counties included: Waupaca, Kewaunee, Shawano, Door, Oconto, Brown, Marinette and Outagamie

No. 7—Rutledge Charities Bldg., Chippewa Falls

Health Officer: (Vacancy)

Counties included: Polk, Dunn, Barron, Rusk, Chippewa, Pierce, St. Croix and Eau Claire

No. 8—City Hall, Rhinelander

Health Officer: Dr. Francis Cline

Counties included: Taylor, Price, Lincoln, Oneida, Forest, Vilas, Florence and Langlade

No. 9—Vaughn Library Building, Ashland

Health Officer: (Vacancy)

Counties included: Douglas, Bayfield, Burnett, Washburn, Ashland, Sawyer and Iron

Maternity Hospitals and Convalescent Homes—Allan Filek, M. D., Acting Director

Bureau of Public Health Nursing—Janet Jennings, R. N., M. A., Director

Division of Industrial Hygiene—Allan Filek, M. D., Acting Director

Division of Hotel & Restaurants—Harold E. Olson, Supervisor

AN OVER-ALL VIEW

The State Board of Health determines policies for the administration of the department and adopts rules and regulations pertaining to its statutory functions. This board consists of seven members appointed by the governor and confirmed by the senate for seven-year terms. The Board selects its own secretary, who is also the state health officer.

The work of the Board and of the department under its jurisdiction is supplemented by local boards of health and health officers in all towns, villages, and cities of Wisconsin. To assist in any local problem that may arise, the State Board keeps in constant touch with local boards and health officers through its district health officers.

With funds made available through the United States Public Health Service and the Children's Bureau, it has been possible to enlarge the work of the State Board of Health in tuberculosis control, venereal disease control, cancer control, maternal and child health, industrial hygiene, nutrition, mental health, and hospital construction.

The various bureaus, divisions, and units of the department are organized on a functional basis that falls into five main sections: General Administration, Local Health Administration, Environmental Sanitation, Preventable Diseases, and Maternal and Child Health. The activities of each division or unit are described very briefly on the following pages.

FUNCTIONS AND ACTIVITIES

General Administration Section

General Administration is concerned chiefly with the coordination of activities for the entire department. It does, however, direct the duties of the following divisions.

Personnel assists in the selection of qualified persons through civil service to fill vacancies; promulgates within the limits of existing rules and regulations a program for employe development, including promotions, transfers, service ratings, vacation, and sick leave; maintains equitable job alignment; and assists in development and administration of such training programs as are deemed necessary.

Budget and Accounts prepares state and federal budgets, payrolls and audits for expenditures for all funds; estimates receipts and expenditures for inclusion in request to the state legislature for funds; maintains records of all appropriations, allotments, and receipts and expenditures of the department and those covering the state tuberculosis institutions at Lake Tomahawk and Statesan. In addition, it audits the reports of county tuberculosis sanatoria for payment of state aid.

Laboratories.—Physicians shall be furnished free of charge with results of laboratory analyses of specimens sent for determining diagnosis of disease. Laboratories are located at Madison, Rhinelander, Oshkosh, Green Bay, Superior, Beloit, Kenosha, Wausau, Sheboygan and La Crosse.

The materials which are examined in these laboratories are sputum for tubercle bacilli; swabs for diphtheria bacilli and other organisms; pus for gonococci and other organisms; central nervous systems of dogs and other animals for Negri bodies diagnostic of rabies; spinal fluid for meningococci and other organisms; materials in suspected cases of anthrax, glanders and actinomycosis; blood, feces and urine for the diagnosis of typhoid and paratyphoid fever (blood only for tularemia and undulant fever) or to detect carriers of these germs; and chemical and bacteriologic examination of water to detect its fitness for drinking purposes. The examination of tissue in suspected cases of malignancy is done only in the laboratory in Madison, and only in those cases wherein the patients are unable to pay a special fee. Such tests are made free for physicians, and the facilities of the laboratories are urged upon the physicians of Wisconsin in the effort to detect and combat communicable disease. Pneumonia typing is now a valuable service offered by the laboratories.

State biologic products.—Under the law, local boards of health are required, under the direction of the State Board of Health, to furnish antitoxin to indigents suffering from communicable diseases. The State Laboratory of Hygiene at Madison has typhoid-paratyphoid vaccine available for distribution free of charge to physicians in the state. Tuberculin diluted 1 to 1,000 is available for group testing by the Mantoux test.

Vital Statistics keeps the official, permanent record of all births, stillbirths, marriages, divorces, and deaths, and tabulates the official data on these records in conformity with the rules governing the International Registration Area. For a nominal fee partial or certified copies of these records can be obtained upon request. The standard forms for reports are issued and frequent tests conducted to determine the completeness of registration. (See chapter 69—1947 Wisconsin Statutes.)

Microfilm Laboratory produces microfilm and photostats of birth, death, and marriage certificates or other material as required by the Board of Health, and furnishes any of these services at cost to other state agencies. X-ray films from the state mobile x-ray units are also processed.

Statistical Services provides tabulating and statistical service to all of the sections and divisions of the State Board of Health. Original reports and documents checked and coded in the various divisions are routed to the statistical service division for machine processing, statistical tabulation and analysis. These tables and analyses are referred to the divisions concerned for final interpretation and are then used in program planning on state and local levels.

Dental Education plans and directs a state-wide program of dental health education and research; conducts controlled studies of the effects of fluorination of water in the prevention of dental caries; and at present is demonstrating the topical application of fluorides to teeth in certain areas in the state.

Health Education supervises various health education activities of the department; promotes and develops health education activities in local health departments and in official and nonofficial agencies interested in health.

Visual Aids loans motion pictures, slides, and film strips on health subjects to schools and other groups in the state; prepares exhibits, posters, and other aids through the services of a health educator and an illustrator to disseminate health education.

Publications prepares and submits to the Wisconsin press articles on all phases of health, aimed at promoting public interest and knowledge; edits the Bimonthly Bulletin, the Biennial Report, and pamphlets on health subjects.

Social Hygiene provides lecturer-counselors in social hygiene to schools and other organizations; assists upon request any school in integrating social hygiene into the curriculum; writes articles and pamphlets on sex education; and stimulates local social hygiene programs.

Hospital Survey and Construction makes an inventory of existing hospitals (general and allied, chronic disease hospitals, mental, tuberculosis sanatoria, public health centers, and related facilities) including public, nonprofit, and proprietary hospitals; surveys the need for construction of hospitals and develops a program for the construction of such public and other nonprofit hospitals as will afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all of the people of the state. The State Act has set up an advisory hospital council to assist and consult in development of the state plan.

In Wisconsin, 60 per cent of the federal funds are allocated for general hospital facilities, the remaining 40 per cent for other categories, such as chronic disease hospitals, mental hospitals, tuberculosis sanatoria, public health centers, or related facilities. The Plan establishes a list of priorities for sixty-six areas of the state for the approval of general hospitals. The priority is based primarily on the relative need for hospital facilities, although special consideration is given to rural areas and areas with low financial resources. The approval of projects in categories other than general hospitals is determined from year to year and approved by the State Board of Health, according to the number and type of applications on file and the need which exists for these specific projects from the area of application. Applications are received up to and including the beginning of each fiscal year starting on July 1, and projects are approved shortly thereafter within the limitation of the federal funds available. Twenty-four projects have already received initial or final approval during the first three years of the program. Nineteen are for general hospital beds, the remaining five for other categories, namely, chronic disease (1), combination chronic disease and psychiatric (2), acute mental (1), and state laboratory (1). These projects have absorbed all of the federal aid available during the first three fiscal years of the program. It is estimated that it will be possible to approve another twenty-five to thirty projects for the remaining five years of the program. Wisconsin's share of the federal grant amounted to $3,000,000 annually, beginning with the fiscal year 1949–1950. The Wisconsin plan provides that 55 per cent of the construction costs be borne by the applicant. Applications for federal grants-in-aid and other detailed information may be obtained from the Division of Hospital Survey and Construction, Room 607 Insurance Building, Madison, Wisconsin.

Cosmetology enforces state laws governing cosmetology; supervises apprentice training program; examines and licenses all cosmetologists.

Barbering enforces state laws governing barbering; supervises apprentice program; examines and licenses all barbers.

Funeral Directors and Embalmers enforces state laws governing funeral directors, embalmers, apprentices, and funeral establishments; registers apprentices and supervisors training program; examines and licenses all funeral directors and embalmers; licenses funeral establishments.

Preventable Disease Section

With the progress of medical science, many deadly diseases have been reclassified as *preventable.* This section is engaged in the vital task of keeping public health practices up-to-date. The basis for this activity is the systematic collection and analysis of morbidity and mortality data, aimed at directing administrative practices toward a reduction in the causes of sickness and death.

Bureau of Communicable Diseases administers, promotes, and encourages local projects for the prevention of communicable diseases through the agency of the local health officers.

Tuberculosis Control plans and assists in carrying out a comprehensive program aimed at the eradication of tuberculosis. To achieve this, it operates mobile x-ray units for the systematic mass survey of entire counties, and performs specific duties relative to the finding, treating, and rehabilitating of tuberculous persons. A central register of tuberculosis cases to aid local health agencies in the follow-up of all reported and suspected cases of tuberculosis is maintained.

Sanatoria supervises county and private sanatoria and directs the activities of the Wisconsin State Sanatorium and Lake Tomahawk State Camp. Wisconsin State Sanatorium is a 241 bed institution which is operated primarily for the treatment of patients with incipient tuberculosis. Lake Tomahawk State Camp provides for the rehabilitation of male tuberculous patients.

Venereal Diseases accumulates information on the incidence of venereal diseases; seeks to find and bring under treatment all cases in a communicable stage; provides free laboratory service and follow-up of contacts for private physicians.

Cancer Control promotes cancer reporting by the establishment and maintenance of state and local cancer registries with follow-up of patients for the purpose of making statistical studies into factors influencing early diagnosis, early and adequate treatment of patients with cancer. It cooperates with the State Cancer Society, State Medical Society, and the University of Wisconsin in conducting postgraduate medical education.

Heart Disease Control was organized as of July 1, 1949, to explore the possibilities of reducing morbidity and mortality from this group of diseases which is the leading cause of death. At the present time it is difficult to plan for the activities of this division except to set up broad purposes, such as professional and lay education, community service and research. It is expected that initially emphasis may be placed upon rheumatic fever in that this disease category most easily lends itself to a public health activity.

Environmental Sanitation Section

This section exercises general supervision and guidance over public health engineering activities in the state.

Bureau of Sanitary Engineering has specific functions described under the headings immediately following.

Public Water Works maintains general supervision over the installation and operation of public water supplies, including the approval of plans and specifications for construction; inter-state carrier water supply certification in cooperation with the U. S. Public Health Service; issuance of well permits under the ground water conservation law.

Public Sewerage supervises the installation and operation of public sewerage systems, including the approval of plans and specifications for construction.

General Sanitation supervises sanitary control over swimming pools and beaches, camps (recreational, industrial, etc.), garbage and refuse disposal, atmospheric pollution control, cooperative activities in clean, safe milk program, and other miscellaneous sanitation activities.

Slaughterhouses and Rendering Plants inspects and licenses; approves sites and plans for new construction; promotes improved operation of plants.

Plumbing Division licenses plumbers; enforces the state plumbing code; promotes adequate plumbing and sanitation in rural and urban areas, including the approval of plans for comfort stations and lake and stream plots.

Well Drilling and Ground Water Control registers well drillers; administers the pure drinking water law and the state well construction code, issues permits on high capacity wells and supervises ground water developments.

Water Pollution conducts pollution surveys; studies trade wastes and other pollution abatement measures, supervises aquatic nuisance control procedures, and renders other services for the State Committee on Water Pollution.

Local Health Administration Section

This section is concerned with planning, organizing and supervising the activities of the Division of Local Health Administration and of all district offices, county, city-county, and multiple county health departments and other bureaus and divisions in the section. It is the channel through which all units of the department reach the various local health units in the state and through which local health units reach the various bureaus and divisions of the State Health Department.

Division of Local Health Administration plans for, and assists in, the development of full-time city-county, county, and multiple county health departments throughout the state. It advises and assists local health officials in the 1,700 health districts through the nine district health officers. Help is given to local health departments in evaluating and directing their programs; making surveys and studies of local needs; securing financial aid; preparing budgets for local health departments; planning and promoting a continuous program of professional education for public health personnel.

Maternity Hospitals inspects and licenses all establishments which care for maternity patients.

Convalescent and Nursing Homes and Homes for the Aged inspects and accredits all such establishments which apply for accreditation.

Nine District Health Offices.—The state has been divided into nine districts by the State Board of Health with a full time medical officer in charge of public health activities in each district. An advisory public health nurse, sanitary engineer and secretary make up the staff in each office. The personnel of these offices is available upon request for consultation on any questions pertaining to public health, control of communicable disease, public health nursing or sanitation. A few of the districts have additional public health personnel such as a stream pollution engineer, nutritionist, dental hygienist, or a hearing consultant. Many of the districts have been assigned a hotel and restaurant inspector.

Bureau of Public Health Nursing gives consultant service to public health nurses and to public and voluntary health organizations regarding public health nursing policies and administration. It studies and analyzes reports of local public health nurses and prepares manuals, guides, records and report forms to aid the local nursing services in guidance of local programs. A register of public health nurses is maintained and credentials of qualified applicants are supplied to any employing body. It plans, encourages and participates in continuous staff education programs for state, district, and local public health nursing staffs. It assigns and supervises rural field experiences for public health nursing students.

Industrial Hygiene Division makes studies to determine whether workers in all types of industries are exposed to poisonous dusts, fumes, vapors, or gases. If harmful exposures are found, recommendations for control are made to the management. It promotes medical programs that include physical examinations (pre-employment and periodic reexaminations). Annual clinics for practicing physicians are organized on industrial health and safety problems. Research is conducted to develop new equipment and methods to detect the toxic effects of new industrial chemicals. This division works closely with the State Industrial Commission and other state departments to carry out an effective program.

Division of Hotels and Restaurants inspects and recommends proper sanitary conditions in hotels and restaurants to assure the public of good wholesome food, properly prepared and served, as well as a safe and sanitary environment. Hotels, restaurants, and tourist rooming houses are licensed. Inspection is made of summer resort hotels, tourist rooms, cottages and tourist cabins, roadside stands, taverns that serve food, and eating places at fairs, carnivals

or other similar gatherings to assure the public that a standard of sanitation and safety is maintained. Food handlers' schools are conducted continuously throughout the state.

Maternal and Child Health Section

The activities of this section are aimed at the conservation of life and the establishment and maintenance of good physical and emotional health for mothers and children.

Bureau of Maternal and Child Health acts in an advisory capacity to other divisions and state and local agencies on matters pertaining to health of mothers and children; studies and interprets statistical data; participates in in-service training and community education programs; prepares and distributes educational material, including a prenatal letter service to expectant mothers; demonstrates community activities; conducts special studies of health problems; and aids poorer counties in maintenance of minimum services.

Nutrition Service provides current information on nutrition and promotes its practical application in the home, school, and community; assists in making studies of community nutrition needs and in organizing appropriate programs; provides consultation service and develops pre-service and in-service training programs for public health nurses, teachers, school administrators, and other professional workers; gives dietetic advisory assistance to administrators of group feeding programs in schools, hospitals, other institutions, and children's camps.

Obstetric and Pediatric Consultation provides medical consultation in obstetrics and pediatrics; makes funds available to bring outstanding obstetricians and pediatricians to Wisconsin to participate in postgraduate medical programs.

Nursing Consultation provides nursing consultation to hospitals and public health agencies to help them establish adequate health programs for mothers and children; assists in interpreting community health needs and problems, educating staff and student nurses, developing programs for parent education, demonstrating nursing technics in the care of mothers and children; coordinates the education and work of public health nurses with activities of other health and social agencies.

School Health.—Local physicians participating in school examination programs or in community programs to examine children prior to school entrance may wish to obtain a copy of the School Health Series Bulletin No. 8 entitled "School Health Examinations." Copies of the examination blank recommended by the State Medical Society Committee on School Health as well as the referral blank for examination of teachers and other school personnel are also available. This referral blank is required by the 1947 revision of 40.16 (14) of the Wisconsin Statutes regarding health examination of school personnel and children. Physicians who are members of local school health councils or school boards may also be interested in instructional materials developed for school use. Among these is the newly revised "Wisconsin Handbook on Health for the Elementary Teacher."

Hearing Conservation.—A demonstration program paralleling the program of the Bureau for Handicapped Children has been set up in Marathon County and the Eighth Health District, which includes Florence, Forest, Langlade, Lincoln, Oneida, Price, Taylor, and Vilas counties. After an initial screening of all school children assistance will be given the communities for obtaining otologic services and hearing aids for children when needed. Doctors within the demonstration area may refer to the hearing consultant at the Rhinelander office any preschool children suspected of hearing loss if other facilities are not available for obtaining audiometric tests.

Mental Health organizes educational and clinical programs in preventive aspects of mental health; demonstrates and supervises local community centers; conducts training center for professional workers; participates in postgraduate medical education in preventive psychiatry and in-service training programs for public health workers, teachers, social workers; carries out program of lay education through all media; acts in advisory capacity on mental health matters to organizations and agencies; conducts studies on mental health problems.

Local Preventive Mental Health Services in Wisconsin:

Brown County Child Guidance Center, 523 Howe Street, Green Bay: Elizabeth D. Kane, M. D., Director.

Dane County Child Guidance Center, 22 North Hancock Street, Madison: Eugenia S. Cameron, M. D., Director.

Dodge County Child Guidance Center, Court House, Juneau: Joseph Weber, M. D., Director.

Douglas County Child Guidance Center, City Hall, Superior: Lawrence R. Gowan, M. D., Director.

Fond du Lac County Child Guidance Center, Court House, Fond du Lac: Elizabeth D. Kane, M. D., Director.

Jefferson County Child Guidance Center, Court House, Jefferson: Hertha Tarrasch, M. D., Director.

Kenosha County Mental Hygiene Clinic, Senior High School, Kenosha: Harold T. Schroeder, M. D., Director.

La Crosse County Child Guidance Center, Vocational School, La Crosse: C. F. Midelfort, M. D., Director.

Manitowoc County Child Guidance Center, Manitowoc: Keith Keane, M. D., Director.

Milwaukee County Guidance Clinic, Public Safety Building, Milwaukee: Gilbert Rich, M. D., Director.

Racine County Guidance Clinic, City Hall, Racine: Harold T. Schroeder, M. D., Director.

Rock County Child Guidance Center, 26 South Bluff Street, Janesville: Hertha Tarrasch, M. D., Director.

Sheboygan County Guidance Clinic, 419 Security National Bank Building, Sheboygan: Keith M. Keane, M. D., Director.

Walworth County Child Guidance Center, School for the Deaf, Delavan, Robert Jones, M. D., Director.

Waukesha County Child Guidance Center, Court House, Waukesha: Harold T. Schroeder, M. D., Director.

Winnebago County Child Guidance Center, Court House, Oshkosh: L. Elizabeth Henning, M. D., Director.

COMMUNICABLE DISEASE RULES

Communicable Diseases

Summary of Rules

Disease	Reportable	Isolation Patient	Restriction Contact	Placard
Actinomycosis	Yes	None if under medical care	None	None
Amebic dysentery	Yes	Food handling restricted	Food handling restricted	None
Anthrax	Yes	Until lesions healed	None	None
Bacillary dysentery	Yes	Food handling restricted	Food handling restricted	None
Brucellosis	Yes	None	None	None
Chickenpox	Yes	7 days from onset	None	None
Cholera	Yes	14 days or negative stools	5 days or negative stools	Yes
Diarrhea of the newborn	Yes	Special; see rule	See rule	None
Diphtheria	Yes	10 days and negative cultures	5 days and negative cultures	Yes
Encephalitis	Yes	7 days from onset	None	None
German measles	Yes	7 days from onset	None	None
Hemorrhagic jaundice	Yes	None	None	None
Hepatitis, infectious	Yes	7 days from onset	None	None
Histoplasmosis	Yes	None	None	None
Leprosy	Yes	Yes; see rule	None	None
Malaria	Yes	Until blood negative for parasites	None	None
Measles	Yes	7 days from start rash	Susceptibles: 7 days beginning 2nd week exposure	None
Meningitis, meningococcal	Yes	14 days; see rule	None	None
Mumps	Yes	Minimum 7 days	None	None
Ophthalmia neonatorum	Limited	None if under medical care	None	None
Plague	Yes	Minimum 14 days	In pneumonic form, 7 days last exposure	Yes
Poliomyelitis	Yes	14 days from onset	Intimate contacts only; see rule	Yes
Psittacosis	Yes	During acute stage disease	None	None
Rabies	Yes	None if under medical care	None	None
Rheumatic fever	Yes	None	None	None
Smallpox	Yes	Until disappearance crusts and scabs	18 days or successful vaccination within 3 days of exposure	Yes
Scarlet fever, septic sore throat	Yes	14 days or negative cultures	Limited; see rule	Yes
Erysipelas, puerperal Infection	No	During acute stage disease	None	None
Tetanus	Yes	None	None	None
Tinea capitis	Yes	Limited; see rule	None	None
Trachoma	Yes	None if under medical care	None	None
Trichinosis	Yes	None	None	None
Tuberculosis	By name	Special; see rule	None	None
Tularemia	Yes	None	None	None
Typhoid fever	Yes	7 days after symptoms and negative cultures	Food handling restricted	Yes
Typhus	Yes	During febrile period	Delousing	None
Venereal diseases	Special	None if under medical care	Examination	None
Whooping cough	Yes	28 days from onset	Limited; see rule	None
Yellow fever	Yes	7 days	None	None

CD 1.00 Communicable Diseases

The following are declared to be communicable diseases and the control measures for each specific disease shall be as herein provided. All reasonably suspected cases of communicable diseases shall be regarded as actual cases until proved otherwise and all rules and regulations applicable to actual cases shall be applied to them.

CD 1.01 Actinomycosis

A. Patient: (1) Placard—None. (2) Restrictions: Isolation: None, provided the patient is under medical supervision. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of discharges from lesions and articles soiled therewith. (2) Terminal disinfection by thorough cleaning.

CD 1.02 Amebic Dysentery

A. Patient: (1) Placard: None. (2) Restrictions: Isolation—none. No person having amebic dysentery, or who is a carrier of amebic dysentery, shall handle, prepare, or serve food for public consumption until completion of treatment and three negative stool tests, taken not less than one day apart, are obtained. (3) Reporting: All cases and carriers of amebic dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

B. Contacts: Restrictions: Quarantine—none. Contacts within the home are prohibited from handling or preparing food for public consumption until 2 negative stool tests, on consecutive days, are obtained.

C. Environment: (1) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements. (2) Concurrent Disinfection: Sanitary disposal of the bowel discharges is required.

CD 1.03 Anthrax

A. Patient: (1) Placard—None. (2) Restrictions —Isolation until the lesions have healed. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of the discharges from lesions and articles soiled therewith. (2) Terminal disinfection: Thorough cleaning.

CD 1.04 Bacillary Dysentery

A. Patient: (1) Placard—none. (2) Restrictions: Isolation—none. No person having bacillary dysentery, or who is a carrier of bacillary dysentery shall handle, prepare or serve food for public consumption which is not subsequently to be cooked until completion of treatment and 2 negative stool tests

taken not less than one day apart. (3) Reporting: All cases and carriers of bacillary dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

B. Contacts: Restrictions: Quarantine none. Contacts within the home are prohibited from handling or preparing food for public consumption until 2 negative stools are obtained.

C. Environment: (1) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements. (2) Concurrent disinfection: Sanitary disposal of the bowel discharges is required.

CD 1.05 Brucellosis

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: None. (2) Terminal disinfection: None.

CD 1.06 Chickenpox

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated for seven days at home from date of onset. (3) Reporting: All cases are to be reported to the local health officer. The diagnoses of all cases of chickenpox occurring in persons over 15 years of age are to be verified by a physician. Where a physician is not employed by the family, the local board of health is required to furnish a physician for the verification of such diagnosis.

B. Contacts: Restrictions: Quarantine none. Well children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

C. Environment: There is to be concurrent disinfection of all articles soiled by discharges from the nose and throat as well as from the lesions.

CD 1.07 Cholera

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated in a hospital or a well screened room for fourteen days or until the stool is found to be free from cholera vibrio on three consecutive days. (3) Reporting: All cases are to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: All contacts are to be quarantined for a period of five days from the date of last exposure and until 2 negative, consecutive cultures are obtained.

C. Environment: (1) Concurrent disinfection. There is to be prompt and thorough disinfection of the stools and vomitus. Articles used by and in connection with the patient are to be disinfected. Food left by the patient is to be burned. (2) Terminal disinfection: The room in which a patient was isolated is to be thoroughly cleaned.

CD 1.08 Diarrhea of the Newborn

A. Patient: (1) Placard none. (2) Restrictions: Immediate removal of affected baby from nursery to isolation ward. Closure of contaminated nursery to new admissions and suspension of maternity service. (3) Reporting: The occurrence of any case of diarrhea of the newborn is to be immediately reported to the local health officer in those communities which employ a full-time health officer. In those communities where a full-time health officer is not employed, the occurrence of diarrhea of the newborn is to be reported directly to the Wisconsin State Board of Health.

B. Contacts: Restrictions: All exposed babies in the nursery are to be cared for by separate medical and nursing personnel.

C. Environment: (1) All articles within the nursery are to be disinfected as thoroughly as practical. (2) Terminal disinfection—thorough cleansing of the premises.

CD 1.09 Diphtheria

A. Patient: (1) Placarding required. (2) Restrictions: The patient is to be isolated for at least ten days and until 2 consecutive, negative nose and throat cultures, taken not less than twenty-four hours apart, are obtained. (3) Reporting: All cases and carriers shall be reported to the local health officer.

B. Contacts: Restrictions: All intimate contacts are to be quarantined for at least five days and until 2 consecutive, negative nose and throat cultures are obtained. Children in the family with the patient may not return to school until all persons within the affected household have been shown to no longer carry the etiologic agent.

C. Environment: (1) All carriers of diphtheria bacilli are to be handled as cases unless laboratory examination demonstrates that the organisms are not virulent. (2) All articles which have been in contact with the patient and all articles soiled by discharges of the patient are to be concurrently disinfected.

CD 1.10 Encephalitis

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated in a well-screened room for an interval of seven days from the onset of the disease. (3) Reporting: All cases are to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 1.11 German Measles

A. Patient: (1) Placard none. (2) Restrictions: Isolation at home for seven days from onset. (3) Reporting: All cases are to be reported to the local health officer.

B. Contacts: (1) Restrictions: Quarantine none. (2) Other children in the family may attend school but are to be observed by the teacher and excluded if they show evidence of illness.

CD 1.12 Hemorrhagic Jaundice

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: Urine and other discharges of patient. (2) Terminal disinfection: None.

CD 1.13 Hepatitis, Infectious

A. Patient: (1) Placard—None. (2) Restrictions: Isolation during the first week of illness. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: Discharges of nose, throat, and bowels of the patient. (2) Terminal disinfection: None.

CD 1.14 Histoplasmosis

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: No requirements.

CD 1.15 Leprosy

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated at home until transferred to a national leprosarium. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of all discharges and articles soiled with discharges from the patient. (2) Terminal disinfection: Cleansing of premises after removal of patient.

CD 1.16 Malaria

A. Patient: (1) Placard none. (2) Restrictions: Isolation in a well-screened room until blood is negative for parasites. (3) Reporting required.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 1.17 Measles

A. Patient: (1) Placard none. (2) Restrictions: Isolation at home for seven days upon appearance of rash. (3) Reporting required.

B. Contacts: Restrictions: Susceptible contacts in the home are to be restricted to the premises beginning the second week after exposure for a period of seven days.

C. Environment: Concurrent disinfection: All articles soiled with secretions of the nose and throat are to be concurrently disinfected.

CD 1.18 Meningitis, Meningococcic

A. Patient: (1) Placard none. (2) Restrictions: Isolation until forty-eight hours after the institution of treatment with a sulfonamide or penicillin. In the absence of such treatment the patient is to be isolated for two weeks. (3) Reporting: The occurrence of meningococcic meningitis is to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: There is to be concurrent disinfection of discharges from the nose and throat or articles soiled with these discharges.

Mumps

A. Patient: (1) Placard none. (2) Restrictions: Isolation of patient for at least one week or until disappearance of swelling. (3) Reporting required.

B. Contacts: Restrictions: Quarantine none. Other children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

CD 1.20 Ophthalmia Neonatorum

A. Patient: (1) Placard—None. (2) Restrictions —None provided the patient is under adequate medical supervision. (3) Reporting—None except as provided in Sec. 146.01 (2) which requires reporting to the local health officer in cases not attended by a physician or midwife.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of conjunctival discharges and soiled articles. (2) Terminal disinfection—Thorough cleaning.

D. Prevention: The attending physician or midwife is required to place 2 drops of a 1 per cent solution of silver nitrate in each eye of a newborn child immediately after delivery. Failure to observe this requirement is punishable by a fine of not more than one hundred dollars. (Section 146.01)

CD 1.21 Plague

A. Patient: (1) Placard required. (2) Restrictions: Isolation of patient in a hospital or well-screened room which is free from vermin for a period of at least two weeks. (3) Reporting required.

B. Contacts: Restrictions: Quarantine of persons exposed to the pneumonic form of the disease for a period of one week from the date of last exposure.

C. Environment: (1) Concurrent disinfection of sputum and soiled articles. (2) Extermination of rats and vermin from the premises.

CD 1.22 Poliomyelitis

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated for a period of at least two weeks from the onset of the symptoms.

(3) Reporting: All cases are to be reported to the local health officer as soon as the diagnosis is established. At the time of release from isolation a second report is to be made for the purpose of verifying the original diagnosis and stating whether the patient was afflicted with a paralytic or non-paralytic form of the disease.

B. Contacts: Restrictions: Intimate contacts under 18 years of age are to be quarantined for two weeks. Intimate contacts who are adults: Teachers and others who come in contact with children and food handlers must cease their occupation for an interval of two weeks.

C. Environment: Concurrent disinfection: All discharges from the nose and throat and bowel are to be concurrently disinfected.

CD 1.23 Psittacosis

A. Patient: (1) Placard—None. (2) Restrictions: Isolation during the febrile and acute clinical stage of the disease. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of all discharges. (2) Terminal disinfection—Destruction of infected birds.

CD 1.24 Rabies

A. Patient: (1) Placard—None. (2) Restrictions: Isolation: None if the patient is under medical supervision and the immediate attendants are warned of possibility of inoculation by human virus. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of saliva of patient and articles soiled therewith. (2) Terminal disinfection: None.

CD 1.25 Rheumatic Fever (Active)

A. Patient (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: No requirements.

CD 1.26 Smallpox

A. Patient: (1) Placard required. (2) Restrictions: Isolate until the disappearance of all scabs and crusts. (3) Reporting required.

B. Contacts: Restrictions: Quarantine for eighteen days from date of last exposure unless a successful vaccination has been obtained within three days of exposure.

C. Environment: (1) Concurrent disinfection: No article is to leave the immediate surroundings of the patient without boiling or equally effective disinfection. (2) Terminal disinfection: Thorough cleaning of the premises.

CD 1.27 Streptococcic Diseases, Respiratory Form Scarlet Fever and Septic Sore Throat

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated for fourteen days and until suppurative discharges cease. Where laboratory facilities are available, isolation may be terminated after obtaining two consecutive, negative nose and throat cultures, which are not less than twenty-four hours apart. (2) Reporting required.

B. Contacts: Restrictions: Intimately exposed children shall be quarantined to the premises if the contact is not broken. The period of quarantine shall be the same as the period of isolation for the patient. If the contact is broken, the period of quarantine shall be for five days or until two consecutive, negative nose and throat cultures, not less than 24 hours apart, are obtained. Adult contacts are not to be restricted except in the case of food handlers and teachers. Adults engaged in the preparation, handling and serving of food shall not be permitted to engage in the handling of food for an interval equal to the isolation period of the patient if contact is not broken. If contact is broken, food handlers may not engage in the preparation, handling and serving of food for an interval of five days. Teachers intimately exposed in the place of residence shall not attend school or associate with groups of children for five days after exposure.

C. Environment: (1) Concurrent disinfection: All articles which have been soiled by purulent discharges and all articles which have been in contact with the patient are to be concurrently disinfected. (2) Terminal disinfection: A thorough cleaning of contaminated objects, scrubbing of floors and sunning of blankets to prevent dissemination of infected particles.

CD 1.28 Streptococcic Diseases Other Than Respiratory Erysipelas and Puerperal Infection

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated for the duration of the acute stage of the disease. (3) Reporting none.

B. Contacts: Restrictions none.

C. Environment: (1) Concurrent disinfection: Careful disposal of dressings and discharges from the patient. (2) Terminal Disinfection: General thorough cleaning of blankets, linen, and room.

CD 1.29 Tetanus

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection—None. (2) Terminal disinfection—None.

CD 1.30 Tinea Capitis (Ringworm scalp)

A. Patient: (1) Placard—None. (2) Restrictions: Exclusion from school until recovery unless (a) under continuous treatment of physician licensed to practice medicine, and wears a suitable head covering until cured, or (b) separate class room provided for infected patients. (3) Reporting required.

B. Contacts: Upon discovery of a clinical case of ringworm of the scalp, all contacts under 15 and all school children in the classroom should be inspected and examined with suitable filtered ultraviolet light. Resurveys should be continued until one month after last case is detected.

C. Environment: (1) Concurrent disinfection — Stocking caps and inexpensive head coverings should be frequently laundered and destroyed by burning after use. (2) Terminal disinfection—None.

CD 1.31 Trachoma

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None, if under medical supervision. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of eye discharges and articles soiled therewith. (2) Terminal disinfection—None.

CD 1.32 Trichinosis

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts—No restrictions.

C. Environment: (1) Concurrent disinfection—None. (2) Terminal disinfection—None.

CD 1.33 Tuberculosis

A. Patient: (1) Placard—None.

(2) Restrictions: *(a)* All individuals afflicted with tuberculosis of the lungs in the communicable form or reasonably suspected of being so afflicted shall exercise all reasonable precautions so as to prevent the infection of others with whom they may come in contact. The principal reasonable precautions are declared to be:

1. Depositing sputum in a special receptacle and disposing of material by burning or thorough disinfecting.
2. Preventing spraying when coughing by coughing into a container or paper napkin held to the mouth or nose.
3. Using individual eating utensils sterilized by boiling after each use.
4. Using separate towels.
5. Sleeping alone.
6. Avoiding coming in contact with other individuals on all possible occasions.
7. Refraining from handling liquids or foodstuffs to be consumed by others or the utensils connected with such handling.

(b) Any individual afflicted with tuberculosis of the lungs in the communicable form, diagnosed as such by a licensed physician or as shown by x-ray or the presence of tubercle bacilli in the sputum, in order to protect others from becoming infected, may be isolated on his premises by the local board of health or the health officer on the direction of the State Board of Health or state health officer, or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction.

(c) A placard shall be posted in a conspicuous position on the premises, with the words "communicable disease" in letters not less than two inches high.

(d) The local board of health or health officer may employ as many persons as are necessary to execute its orders and properly guard any patient in isolation if isolation is violated or intent to violate isolation is manifested. Such persons shall be sworn in as guards, shall have police powers, and may use all necessary means to enforce the state laws for the prevention and control of communicable diseases, or for the enforcement of these rules and regulations.

(e) The expense of maintaining isolation including examinations and tests to determine the presence or communicability of the disease, and the enforcement of isolation on the premises shall be paid by the city, incorporated village or town upon order of the local board of health. The expenses for necessary nurses, medical attention, food and other articles needed for the comfort of the afflicted person shall be charged against him or whoever is liable for his support. Indigent patients shall be cared for at public expense.

(f) Any individual who has been isolated on the premises under provision of these rules shall be released from such isolation by the local board of health or health officer on direction of the State Board of Health or state health officer or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction when in the opinion of said health officer the isolation is no longer necessary to protect others from becoming infected.

(g) No person with tuberculosis of the lung or other part of the respiratory tract in the communicable form, or reasonably believed to be suffering from such disease, shall be permitted to attend or frequent any school except open-air schools especially equipped for the purpose until the health officer of the municipality where the school is situated furnishes a written certificate stating that the individual is free from a communicable form of tuberculosis. Such certificate shall only be issued after thorough examination by a licensed physician in a manner satisfactory to the State Board of Health.

(h) If an individual afflicted with tuberculosis in a communicable form shall leave the sanatorium against the advice of the medical superintendent or medical supervisor, such an individual shall be reported to the local board of health and may be isolated upon his premises as provided in Section B if in the opinion of the State Board of Health or the state health officer or of the full-time medical health officer of cities or counties with a population of 250,000 or more, agree that isolation is necessary in order to protect others from becoming infected.

(i) The local health officer or an individual delegated by him shall visit all individuals isolated for tuberculosis at least once every 15 days to ascertain that the isolation is being maintained and to ascertain whether to make recommendations for release from isolation or for admission to a tuberculosis sanatorium.

(j) Any individual isolated for tuberculosis may obtain release from such isolation by being admitted to a tuberculosis sanatorium.

(k) Individuals afflicted with tuberculosis in any form and diagnosed as such by a competent physician shall exercise every care and precaution for the protection of others.

(3) Reporting—By name to local health officer.

B. Contacts: No restrictions.

C. Environment: Disinfection: All handkerchiefs, towels, cloths, eating utensils and other contaminated material used by a person with tuberculosis shall receive appropriate disinfection before coming in contact with others. Upon the death or removal of a person with tuberculosis the health officer shall require disinfection of the premises occupied by the patient by a thorough washing of the woodwork by soap and water or a disinfectant, boiling of the dishes and contaminated fabrics, and a thorough sunning of material which can not be subjected to other disinfection.

It is the intent of these rules and regulations to give reasonable protection to the public from exposure to an individual afflicted with pulmonary tuberculosis in the communicable form.

CD 1.34 Tularemia

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of discharges from the ulcer, lymph glands, or conjunctival sac. (2) Terminal disinfection—None.

CD 1.35 Typhoid Fever

A. Patient: (1) Placard required. (2) Restrictions: Isolation for at least one week beyond the time that all symptoms subside and until two negative, consecutive specimens of feces and urine are obtained at least five days apart. (3) Reporting required.

B. Contacts. (1) Quarantine none. (2) Family contacts are not to be permitted to handle food during the period of contact or before two negative, consecutive stool and urine cultures are obtained.

C. Environment: (1) Concurrent disinfection of all bowel and urinary discharges and articles soiled with them. (2) Terminal disinfection through a thorough cleaning of the premises. (3) Suppression of flies.

D. Typhoid (Paratyphoid) Carrier:

1. Definition: A person shall be considered a typhoid (paratyphoid) carrier, capable of transmitting the disease to susceptible persons if:

(a) During or following his convalescence from the disease his feces and urine have not been proved free from typhoid (or paratyphoid) bacilli by examination in an approved laboratory (temporary carrier).

(b) He has not suffered from typhoid (or paratyphoid) fever within one year, but typhoid (or paratyphoid) bacilli are found in his urine or feces when examined in an approved laboratory (chronic carrier).

(c) Epidemiologic evidence points to such person as the source of one or more cases of the disease and from whom for any reason specimens of urine or feces have not or can not be obtained for examination in an approved laboratory.

2. Rules:

(a) The urine and feces of a typhoid carrier shall be disposed of in such a manner as not to endanger any public or private water supply or be accessible to insects or rodents.

(b) If food products, which are to be consumed raw by others, are produced on premises occupied by a typhoid carrier, the water supply shall be proved free from contamination.

(c) No typhoid carrier shall engage in the handling or preparation of any food or drink to be consumed on the premises by others than members of his family with whom he resides or to be consumed off of the premises prior to cooking. This restriction shall apply to visitors, roomers, lodgers, and employes.

(d) No typhoid carrier shall engage in the occupation of nurse, nurse-maid, domestic servant, cook, waiter, dishwasher, or public eating-house employee.

(e) No typhoid carrier shall engage in any occupation involving the handling of milk, cream, or milk products, or the utensils used in the production thereof. No typhoid carrier shall reside on premises where milk is produced for distribution off of the premises unless the carrier, or if he be a minor, his parent or legal guardian, and the owner of the milk-producing cows agree in writing:

(1) That the carrier will not engage in milking or handling of milk, cream or dairy utensils, nor enter the house or barn where milk is produced or handled.

(2) That no milk or cream is to subsequently be sold nor any utensils used in the production of milk or cream shall be brought into the house occupied by the carrier.

(3) That all persons residing or employed on the premises who are susceptible to typhoid shall be vaccinated against typhoid fever at least every three years.

Where the provisions of such agreement are not followed, distribution and sale of milk from such premises are prohibited.

(f) No typhoid carrier shall reside in or be employed in a boarding house or camp.

(g) No carrier shall change his place of residence without notifying the local health officer of his intended residence, who shall immediately inform the State Board of Health of the facts.

(h) In any situation not covered by the above rules and in which a typhoid carrier endangers the public health, the carrier shall observe such recom-

mendations as the State Board of Health may make for the particular case.

3. Release of typhoid carriers:

(a) Following isolation for typhoid fever a person adjudged a temporary carrier may be released from restrictions only after two successive specimens each of urine and feces, passed at an interval of not less than five days, shall have been examined in an approved laboratory and found free from typhoid (or paratyphoid) bacilli; except that if the person is to handle milk, dairy or food products the number of negative cultures shall be four, two of which shall have been examined in the State Laboratory of Hygiene.

(b) A person adjudged a chronic carrier and who has not suffered from typhoid (or paratyphoid) fever within one year may be released from restrictions only on approval of the state health officer, and after certain conditions have been met.

4. Conditions for release of chronic typhoid carriers:

(a) If the gall bladder has not been removed

(1) Three specimens of duodenal contents taken in a hospital at intervals of not less than 24 hours shall have been examined in an approved laboratory and found to contain no typhoid bacilli.

(2) Each of at least 18 successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution, have been examined in the State Laboratory of Hygiene and found to contain no typhoid bacilli.

(b) If the gall bladder has been removed

(1) Subsequent to removal of gall bladder each of three specimens of duodenal contents, taken in a hospital at intervals of not less than 24 hours, shall have been examined in an approved laboratory and found to contain no typhoid bacilli.

(2) Each of at least six successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution, has been examined in the State Laboratory of Hygiene and found to contain no typhoid bacilli.

CD 1.36 Typhus

A. Patient: (1) Placard—None. (2) Restrictions: Delousing, isolation in vermin-free room during febrile period. (3) Reporting required.

B. Contacts—Restrictions: None required if delousing carried out.

C. Environment: (1) Concurrent disinfection—Use of insecticide powders on clothing and bedding and special treatment of hair for nits. (2) Terminal disinfection—None.

CD 1.37 Venereal Diseases

A. The State Board of Health declares the following venereal diseases, namely, syphilis, gonorrhea and chancroid as contagious, infectious, communicable and dangerous to the public health.

B. All Infected Persons Subject to Control.—All persons having venereal disease shall be subject to such control as public safety requires.

C. Who is to Report Venereal Disease.—Any physician who attends, treats or examines a person with venereal disease in communicable form; and any superintendent or manager of a hospital, dispensary, charitable or penal institution having knowledge of any such case not known to be previously reported, shall report such case to the State Board of Health. Such report shall be by designated number, age, sex, conjugal condition and duration of disease. The physician shall inquire into the source of infection and shall report any person known to a reasonable certainty to be the source by name and address to the State Board of Health. Any person knowing of a person with venereal disease not under the care of a physician and believed to be a menace to the public health shall report the name and address directly to the State Board of Health.

D. Reporting of Cases Delinquent in Treatment.—Whenever any person suffering from syphilis, gonorrhea or chancroid in a communicable form shall fail to return to the physician treating such person in reasonable time, such person shall be reported by name and address to the State Board of Health as delinquent in treatment.

E. Examination of Certain Classes Suspected of Having Venereal Disease.—It shall be the duty of each superintendent, manager or physician of any state, county, municipal, charitable or correctional institution, the warden of the state prison, the sheriff and other keepers of any jail or other penal institution to cause an examination to be made of all inmates suspected of having a venereal disease and said examination shall be made by a method satisfactory to the State Board of Health. Vagrants, prostitutes, frequenters of houses of prostitution, and persons guilty of illicit cohabitation are hereby declared to be reasonably suspected to have venereal disease. Any such person found to be infected with any of the venereal diseases in a communicable stage shall be kept in such quarters as not to expose others. Such persons and all legally committed persons with a venereal disease, which is communicable to others, at expiration of commitment shall hereby be considered under quarantine and shall so remain until satisfactory arrangements can be made for care and treatment by a licensed physician at place of subsequent residence or until other disposition of the case is made by the State Board of Health.

F. Isolation.—Whenever a case or suspected case of venereal disease is found on premises where the case cannot be properly controlled during the period of infectiousness, or whenever a person with venereal disease in the infectious stage refuses or neglects care or treatment by a physician licensed to prescribe drugs, or is unmanageable and other persons are endangered, a placard may be placed on the premises occupied by the patient. Such placard shall be applied in emergency and not in lieu of commitment to an institution under Chapter 143.07, Laws of Wisconsin. The placard sign shall have the words

"Communicable Disease." Violation of the requirements imposed by the placard shall be deemed a violation of these regulations. The local health officer shall be required by the State Board of Health to impose such isolation and enforce its requirements.

G. Sexual Contacts—Examination of.—All persons reported to be sexual contacts by any person with venereal disease in a communicable form shall be regarded as suspected cases and may be required by an official of the State Board of Health to be examined by a physician in a manner satisfactory to the State Board of Health.

H. Indigents—Treatment Facilities.—Local health officers and local boards of health shall co-operate with the State Board of Health in establishing treatment facilities for indigent persons with venereal disease. Local health officers shall report to the State Board of Health all cases of venereal disease reported to them.

I. Forbidden Occupations.—Persons suspected to be or knowing themselves to be afflicted with a communicable venereal disease shall not engage in the care or nursing of children or of the sick, nor shall they engage in any occupation the nature of which is such that their infection may be communicated to others. In the interests of the public health a medical health officer or officer of the State Board of Health may confidentially inform any person so endangered.

J. Issuing Certificates of Freedom From Venereal Disease Forbidden.—No physician or health officer shall issue certificates of freedom from any venereal disease to any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons or show, for immoral purposes, venereal disease reports from any laboratory. Such procedure is declared by the State Board of Health to be inimical to public health and public welfare.

K. Minors.—The parents or guardians of minors acquiring venereal disease shall, when notified, be legally responsible for the compliance of such minors with the requirements of these regulations.

L. Communicability—Definition of.—All cases of venereal disease shall be regarded as communicable until the following requirements have been met:

1. Syphilis*

Until open sores, ulcers, rashes, syphilitic sore throat or other open syphilitic lesions are healed; and also until satisfactory care and treatment as hereinafter defined has been given to any of the following: Pregnant women with syphilis; females who have given birth to a syphilitic child; syphilitic persons at any stage of the disease who, reasonable evidence indicates, are promiscuous in sexual relations and are a menace to others; and persons with early syphilis not adequately treated.

Adequate treatment shall be considered to be the administration of not less than twenty doses of arsenicals and twenty doses of heavy metal or equally effective treatment by a physician licensed to prescribe drugs. This other effective treatment shall be such as considered adequate by the State Board of Health.

2. Gonorrhea

A. Male:

1. Freedom from discharge.
2. Clear urine, no shreds.
3. Urethral smears must be negative for gonococci on four successive examinations at intervals of not less than one week.
4. Prostatic smears negative to gonococci on two successive tests.
5. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three month period.

B. Female:

1. No unusual vaginal discharge.
2. Two successive negative examinations for gonococci of the secretions of the urethra, vagina and of the cervix with an interval of at least forty-eight hours, and repeated for four successive weeks.
3. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three month period.

The labia should be held apart and a swab applied so as to express any secretions from Skenes or Bartholin's glands, which is then taken up on the swab.

In preparing urethral slides the finger should be inserted in the vagina and expression made on the floor of the urethra from within outward, the cotton-tipped probe being then introduced well into the meatus. In procuring a smear from the cervix a vaginal speculum should be introduced and the cervix well exposed. All secretions should be mopped away from the external os before taking the smear. After the cervix is well dried a probe tightly wound with cotton should be inserted in the cervical canal and rotated several times.

3. Chancroid

Until all lesions are healed.

CD 1.38 Whooping Cough

A. Patient: (1) Placard none. (2) Restrictions: Isolation for three weeks after onset of typical paroxysms, or a total of twenty-eight days from onset of the catarrhal stage. (3) Report required.

B. Contacts: Restrictions: Other children in the family may attend school but are to be observed by the teacher and excluded if they evidence any symptoms of illness. Those children exposed to whooping cough in whom coughs or colds develop must be kept in isolation in their home until a diagnosis is established.

C. Environment: (1) Concurrent disinfection of the discharges from the nose and throat and of ar-

* Note: Does not apply to Section 143.07, subsection 4.

ticles soiled with such discharges. (2) Terminal disinfection. A thorough cleaning of the premises.

CD 1.39 Yellow Fever

A. Patient: (1) Placard none. (2) Restrictions: Isolation in a well-screened room for seven days. (3) Reporting required on all cases to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent Disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 2.00 Reporting

All communicable diseases which are designated as reportable under these rules shall be reported by all physicians and other persons having knowledge of such diseases to the local health officer and by the local health officer to the State Board of Health unless otherwise specifically provided.

CD 3.00 Definitions

3.01. *Case.* A person whose body has been invaded by an infectious agent, with the result that symptoms have occurred.

3.02. *Carrier.* A person who harbors a specific infectious agent without demonstrating symptoms or signs of the disease.

3.03. *Contact.* A person who has been intimately in contact with an infected person, such as the daily contact of a patient with his parents, his brothers and sisters, other occupants of the home and the like.

3.04. *Isolation.* By isolation is meant the separation of cases or carriers from other persons in such places and under such conditions as will prevent the direct or indirect conveyance of the infectious agent to susceptible persons.

3.05. *Quarantine.* By quarantine is meant the limitation of freedom of movement or isolation of contacts who have been exposed to a communicable disease, for a period of time equal to the longest usual incubation period of the disease to which they have been exposed.

3.06. *Disinfection.* Disinfection denotes the destruction of infectious agents by chemical or physical means. In general, two types of disinfection are employed:

A. *Concurrent.* Disinfection carried on continuously during the illness of the patient, such as destruction by use of chemical or physical means of discharges of the patient and cleaning of any infectious material which has come into contact with the patient or may have been soiled by him.

B. *Terminal.* The elimination of the infectious agent from personal clothing, belongings, and the immediate physical environment of the patient.

CD 4.00 Enforcement

It shall be the duty of the health officer of every local board of health in this state to enforce the rules of the State Board of Health covering communicable diseases or a suspected case of communicable disease whenever a case is reported or becomes known to him within his jurisdiction.

CD 5.00 School Attendance (formerly Rule 17)

All teachers, school authorities, and health officers having jurisdiction shall not permit the attendance in any private, parochial or public school of any pupil afflicted with a severe cough, a severe cold, itch, scabies, lice or other vermin, ring worm, impetigo, epidemic jaundice, Vincent's angina (trench mouth), infectious conjunctivitis (pink eye), or any contagious skin disease, or who is filthy in body or clothing, or who has any communicable disease so designated by the State Board of Health unless specifically exempted in the rules. The teachers in all schools shall, without delay, send home any pupil who is obviously sick even if the ailment is unknown, and said teacher shall inform the parents or guardians of said pupil and also the local health officer as speedily as possible, and said health officer shall examine into the case and take such action as is reasonable and necessary for the benefit of the pupils and to prevent the spread of infection.

Parents, guardians or other persons having control of any child who is sick in any way, or who is afflicted with any disease covered by this rule, shall not permit said child to attend any public, private or parochial school or to be present in any public place.

CD 6.00 Sale of Milk and Dairy Products From Infected Home Restricted

The sale or use of milk or dairy products from a place where cholera (Asiatic), diphtheria, poliomyelitis, plague, scarlet fever, smallpox, or typhoid fever is found to exist is strictly forbidden unless the milk is handled, milk utensils washed and stock cared for and the product transported by persons entirely disassociated from the quarantined family.

CD 7.00 Release Cultures

Where release cultures are required in communicable diseases, such cultures shall be examined in a laboratory approved by the State Board of Health.

CD 8.00 Transporting Patients

When it is necessary to transport a person suffering with a dangerous communicable disease from one town, village or city to another, the consent of the health officer where the patient lives and also the health officer of the town, village or city to which the patient will be transported must first be obtained. Transportation must be made by private conveyance and proper precautions exercised to prevent needless exposure of all persons who may come in contact with the patient during transit.

CD 9.00 Exclusion From School, Assemblages, and Public Conveyances

No person suffering from any communicable disease so designated by the State Board of Health

shall be admitted to any public, parochial or private school, college or Sunday school, or shall enter any theatre, assemblage, or railway car, street car, vessel or steamer, or other public conveyance, except as specifically provided in the communicable disease rules.

CD 10.00 Mail in Placarded Home

No mail or other materials shall be sent from a placarded home unless such mail or materials have been prepared and disinfected under the direction of the local health officer.

CD 11.00 Books Not to Be Taken Into Infected Homes

Schoolbooks or books from public or circulating libraries shall not be taken into any house placarded for communicable disease and if schoolbooks or library books have already been taken in such house they shall be destroyed by the owner or library authorities or thoroughly disinfected.

Disinfection of books—In cases where it is desirable to disinfect books which may have become infected with dangerous communicable disease the following requirements must be followed:

Library books which have been in a placarded home should be withheld from circulation for a period of fifteen days and so arranged each day that the sunlight can reach the maximum number of surfaces.

Books used by a tubercular person should either be destroyed or withheld from circulation for at least one month and during this time kept standing in the sunlight opened so that the rays of the sun can reach the maximum number of pages. Surfaces should be changed from day to day. Time and sunlight are recommended as the best means to accomplish the destruction of infectious material deposited upon books.

CD 12.00 Public Funerals Prohibited

12.01. Public or church funerals shall not be held for persons dead of smallpox. Every person who attends the funeral, including members of the family, shall, within 24 hours of attending the funeral or exposure, submit to vaccination for smallpox or produce evidence from a physician of successful vaccination within the past two years.

12.02. Whenever death is due to cholera (Asiatic), diphtheria, poliomyelitis, plague, or scarlet fever, the household and family contacts of the deceased shall not be permitted to attend public or church funerals for the deceased nor to have any association with the public until the specific restrictions governing contacts have been fulfilled.

12.03. The above rules shall apply to funerals of those dead from suspected cases as well as diagnosed cases of the diseases above specified, but shall not apply to those dying from late complications of such diseases after the communicable period is past, and after the family is released from quarantine.

12.04. During periods of epidemic, diseases of any nature found sufficiently malignant to justify private funerals and in the case of death from unusual forms of virulent disease, apparently communicable in nature, the local board of health with the consent of the State Board of Health may prohibit public funerals of those dead from such diseases.

CD 13.00 Rules Governing the Approval of Laboratories For Doing Serologic Tests as Required by the Marriage License Law

13.01. For approval a laboratory for this purpose must be under the direction of a licensed doctor of medicine, unless otherwise provided by special action of the State Board of Health, who is a recognized pathologist and who devotes at least half of his time to the supervision of such laboratory.

13.02. Each laboratory must make application to the State Board of Health for approval under this provision.

13.03. If there is a change in the directorship of the laboratory it must be reported to the State Board of Health and the laboratory must reapply for approval.

CD 14.00 Food Poisonings

All instances of food poisoning or suspected food poisoning, in which there is reason to believe that the purchase or consumption of the incriminated food occurred at a store or eating place accessible to the general public, shall be reported.

PRESCRIPTION OF NARCOTICS

The question has been asked whether a physician may legally write a prescription for narcotic drugs on the representation of a person other than the patient in a situation in which the physician does not know and has not actually seen thesupposed patient.

The question must be answered with a strong negative. Before narcotics can be prescribed, first, the physician must know that a particular patient exists; second, he must also know, on the basis of examination and diagnosis, that the particular patient needs narcotics or a medicine containing narcotics. The recital of a person other than the patient to the physician is not enough, and the physician who prescribes narcotics for a person he does not know to exist violates the law. See articles on this subject in *The Wisconsin Medical Blue Book*, pages 47 and 50. Physicians are cautioned never to prescribe narcotics for a patient unless the patient is known to exist and until a need for narcotics has been verified.

Provisions of Wisconsin General Hospital Law

ACCORDING to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 **Public patients.** (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 **Application.** When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same time the judge makes an investigation as to the propriety of such a commitment. The supervisor of the town, village or ward of residence of the person is required to furnish the court, upon request, with all material information within his knowledge in order that the judge may intelligently decide the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already overcrowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $12.50 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin.

Classification of patients admitted to the hospital is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state until that county's quota for that year is exhausted in which case the county bears the full cost.

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on $12.50 per day basis. A financial statement of the patient is taken on admission, and if it is felt that his status justifies a $12.50 per day charge, he is admitted on that basis. He is thereby entitled to every service except transfusions and special nursing.

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

4. *War Veterans:* Any honorably discharged veteran of any war of the United States, who has been a resident of the state for not less than five years preceding his admission, may be admitted to the hospital and obtain all care including professional service at the established per diem rate ($5.90). War veterans are required to present their honorable discharge papers and sign a statement declaring residency for the last five years preceding admission to the hospital. War veterans may be admitted as private patients of individual staff members if properly referred, in which case hospital rate is as above, but professional fee applies.

No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.

Divisions of Wisconsin General Hospital

Wisconsin General Hospital: Admissions per above; general hospital service plus teaching privileges in connection with the University.

Wisconsin Orthopedic Hospital: Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wis-

consin General Hospital and with the approval of the Crippled Children's Division.

Bradley Memorial Hospital: This is the psychiatric unit of the Wisconsin General Hospital and not a separate unit.

University of Wisconsin Infirmary: Student health center and hospital.

Wisconsin Psychiatric Institute: Furnishes facilities for blood and spinal fluid Wassermann examinations for the various state agencies and institutions, and for any physician desiring its facilities.

Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. Thus the Attorney General has held that treatment need not be ordered at Madison in the emergency case, even though the expense might be less than in a local institution, because "it is not believed that the treatment at Madison would be considered adequate. . . ." (XXII Atty. Gen. 465). And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned nor as to patients certified to the Wisconsin Orthopedic Hospital. The decision whether there is a hospital in the county is for the secretary of state at the time he certifies to the county its share of the costs. 30 Atty. Gen. 98. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law, no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory, the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also 21 Atty. Gen. 240 and 22 Atty. Gen. 408.

WISCONSIN HOSPITAL ASSOCIATION TO CONVENE IN MILWAUKEE

The annual convention of the Wisconsin Hospital Association will be held at the Hotel Schroeder, Milwaukee, on February 16. Staff members, including trustees, administrators, nurses, accountants, technicians, and dietitians, of all Wisconsin hospitals are invited. The day's program will consist of discussions on building safety into the hospital; Hospital Construction Act, 1950 and progress to date; efficiency in the dietary department; uniform accounting; present hospitalization problems of the State Department of Veterans Affairs; and a ten year partnership in community health. The annual award of merit will be awarded at a luncheon, at which Mr. George Bugbee will speak on "Current National Problems." Following a round-table discussion, the business meeting, with election of officers, will be held.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATURE

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies who have been certified to the headquarters of this Society, and whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

* As amended by the 1949 House of Delegates.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. No address or paper, except those of the president, the president-elect, and the annual orations, or papers presented by out-of-state speakers especially invited, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time.

SEC. 3. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The Secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting during January for purposes of or-

ganization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Council on Scientific Work.
A Council on Medical Service and Public Relations.
A Committee on Public Policy.
A Committee on Grievances.
A Committee on Medical Education and Hospitals.
A Committee on Medical Economics and Voluntary Sickness Insurance.
A Committee on Maternal and Child Welfare.
A Committee on Health and Public Instruction.
A Committee on Coordination of Medical Services.
A Committee on Care of Crippled Children.
A Committee on Goiter.
A Committee on Mental Hygiene, Institutional Care, Public Welfare and State Departments.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Tuberculosis and Chest Diseases.
A Committee on Industrial Health.
A Committee on Hospital Relations.
A Committee on Cancer.
A Committee on Visual Defects.
A Committee on Hearing Defects.
A Committee on Rural Health and Accident Prevention.

Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for a term of three years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, and three years, and thereafter for terms of three years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service and Public Relations shall consist of the chairman of the Council, the president, the past president, the speaker of the House of Delegates, and five members appointed by the president of the Society.

Each appointed member shall serve for a term of five years, provided that of the appointments made in 1946, the terms shall be for one, two, three, four and five years as designated by the incoming president. The Council on Medical Service and Public Relations shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

SEC. 4. The Committee on Public Policy shall consist of three members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of five members and of the additional appointments made in 1949, one shall be for one year, and one shall be for two years.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

SEC. 7. The Committee on Maternal and Child Welfare shall consist of six members and its principal duties shall be to advise cooperating agencies in the effort to reduce maternal mortality and to preserve child health.

SEC. 8. The Committee on Health and Public Instruction shall consist of three members. It shall carry on such activities in the field of health and the dissemination of information in relation thereto as the House of Delegates and Council may direct.

SEC. 9. The Committee on Care of Crippled Children shall consist of six members, and its principal duty shall be to act in an advisory capacity to state departments concerned with the subject matter.

SEC. 10. The Committee on Goiter shall consist of three members, and its principal duty shall be to forward those measures looking toward the prevention of goiter, and where existent, its early diagnosis and treatment.

SEC. 11. The Committee on Mental Hygiene, Institutional Care, Public Welfare and State Departments shall consist of five members. Its principal duties shall be advisory to both the Society and cooperating agencies as to those means best designed to protect mental health and alleviate mental illness.

SEC. 12. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 13. The Committee on Tuberculosis and Chest Diseases shall consist of three members, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of tuberculosis and diseases of the chest.

SEC. 14. The Committee on Industrial Health shall consist of three members, and its principal duties shall be to cooperate with the Council on Industrial Health of the American Medical Association, and to seek to further the health of those employed in industry in Wisconsin.

SEC. 15. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

SEC. 16. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 17. The Committee on Visual Defects shall consist of three members, and its principal duties shall lie in the field of prevention, and where existent, early discovery and treatment. It shall act in an advisory capacity to state departments concerned with these problems.

SEC. 18. The Committee on Hearing Defects shall consist of five members, and its principal duties shall lie in the field of prevention and, where existent, early discovery and treatment. It shall act in an advisory capacity to State departments concerned with these problems. Appointments to this Committee in 1948 shall be for three, four and five year terms, and appointments thereafter shall be for a term of five years.

SEC. 19. The Committee on Rural Health and Accident Prevention shall consist of three members and shall engage in activities in promoting health and safety in rural Wisconsin.

SEC. 20. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2 *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assesments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverse that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 6. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A

county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. At some meeting in advance of the annual session of this Society, each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIII

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid on the table for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

STATE ANTI-TUBERCULOSIS ASSOCIATION OFFERS SCHOLARSHIPS

The Wisconsin Anti-Tuberculosis Association is offering two free scholarships to qualified Wisconsin physicians to attend a four week course in tuberculosis, conducted by the Trudeau School of Tuberculosis at Saranac Lake, New York, May 1–27. Scholarships are open to recent graduates of approved medical schools, with preference to those men who have had some experience with tuberculosis or who plan to specialize in internal medicine. Scholarships include tuition ($100), transportation, ($100), and maintenance ($150). Applications must be in the hands of the committee by March 1. Forms may be obtained from the Wisconsin Anti-Tuberculosis Association, Medical Scholarships Committee, 1018 North Jefferson Street, Milwaukee 2, Wisconsin.

Officers of State Boards and Commissions

Basic Science Examiners

Prof. Michael F. Guyer, President, Zoology Department, University of Wisconsin, Madison, 1955

Prof. William H. Barber, Secretary, Watson and Scott Streets, Ripon, 1951

Mr. H. M. Weeks, supervisor, 1953

State Board of Medical Examiners

J. W. Smith, M. D., President, 324 East Wisconsin Avenue, Milwaukee, 1951

E. W. Miller, M. D., 231 West Michigan Street, Milwaukee, 1953

C. A. Dawson, M. D., Secretary, River Falls, 1951

H. H. Christofferson, M. D., Colby, 1953

A. F. Rufflo, M. D., United States Bank Building, Kenosha, 1953

Alvin G. Koehler, M. D., 46 Washington Boulevard, Oshkosh, 1951

J. W. Prentice, M. D., 522 West Second Street, Ashland, 1951

E. C. Murphy, D. O., 314 East Grand Avenue, Eau Claire, 1953

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control and combine certain other agencies)

Members of the Board

William Studley, M. D., Milwaukee, 1953

Mr. Harold W. Story, Milwaukee, 1951

Mrs. Harrison L. Garner, Madison, 1953

Mr. Ralph Uihlein, Milwaukee, 1951

W. D. Stovall, M. D., Madison, 1955

Mrs. Karl Kleinpell, Cassville, 1955

Mr. Leo Jelinske, Shawano, 1955

Mr. Earl N. Hale, Eau Claire, 1953

Mrs. C. R. Beck, West Allis, 1951

Executive Staff

Mr. A. W. Bayley, Madison, Acting Director

Division of Corrections
Mr. Paul D. Yount, Director

Division of Mental Hygiene
(Vacancy)

Division of Public Assistance
Mr. George M. Keith, Madison, Director

Division of Business Management
Mr. H. B. Evans, Madison, Director

Division of Child Welfare and Youth Services
(Vacancy)

Wisconsin Industrial Commission

Members of the Commission

Mr. Voyta Wrabetz, Chairman, 1955
Mr. Harry J. Burczyk, 1953
Mr. C. L. Miler, 1951
Miss Helen Gill, Secretary

Workmen's Compensation Department
Mr. Harry A. Nelson, Director

Unemployment Compensation Department
Mr. Paul R. Raushenbush, Director

Safety and Sanitation Department
Mr. O. T. Nelson, Director

Women and Child Labor Department
Maude Swett

State Board of Vocational and Adult Education

E. J. Fransway, Employee member_____Wauwatosa
Emil Waldow, Employee member_____Green Bay
Frank C. Horyza, Employee member_____Superior
Jessel S. Whyte, Employer member_____Kenosha
Alfred A. Laun, Employer member_____Kiel
Fred Vogt, Employer member_____Milwaukee
John Last, Farmer member_____Lake Mills
John Wiechers, Farmer member_____Racine
Robert L. Pierce, Farmer member_____Menomonie
G. E. Watson, ex officio_____Madison
Voyta Wrabetz, ex officio_____Madison
C. L. Greiber, ex officio_____Madison
State Director, State Board of Vocational and Adult Education

Rehabilitation Division

State Supervisory Staff

Room 320, State Office Building, Madison

W. F. Faulkes_____Chief
J. H. Brown_____Assistant chief
Charles Beardsley_____Case Service
Irene M. Dunn_____Records
A. E. Towne_____Medical Service
Mary F. Beyer_____Homecraft
Inez F. Belyea_____Medical Social Consultant (on leave)
Edward J. Pfeifer_____Psychological Service
A. W. Bryan, M. D._____Medical Consultant (part time)

District Offices

Madison_____114 North Carroll Street
C. D. Rejahl, District Supervisor

Milwaukee Vocational School Building, 1015 North Sixth Street
L. A. Rumsey, District Supervisor

Green Bay Vocational School Building, 200 South Broadway
A. W. Bouffard, District Supervisor
Eau Claire_____314 East Grand Avenue
F. A. Campbell, District Supervisor

Local Offices

La Crosse Vocational School Building
Carl J. Haase, Case Supervisor
Racine Vocational School Building
V. C. Bryan, Case Supervisor
Wausau Vocational School Shop Building
L. H. Heise, Case Supervisor
Superior_____917 Tower Avenue
H. C. Ritzman, Case Supervisor

STATE MEDICAL ADVISORY COMMITTEE

T. J. Howard, M. D._____Milwaukee
G. F. Wakefield, M. D._____West Salem
J. S. Supernaw, M. D._____Madison
R. M. Kurten, M. D._____Racine
H. L. Greene, M. D._____Madison
H. M. Coon, M. D._____Madison
C. N. Neupert, M. D._____Madison
Charles Fidler, M. D._____Milwaukee
H. H. Reese, M. D._____Madison
H. J. Heeb, M. D._____Milwaukee
Lyman Copps, M. D._____Marshfield
Harry D. Bouman, M. D._____Madison
Miss Marjorie Taylor_____Milwaukee
Miss Janet Jennings_____Madison

AMERICAN ASSOCIATION OF PATHOLOGISTS AND BACTERIOLOGISTS TO CONVENE AT UNIVERSITY OF WISCONSIN

The annual meeting of the American Association of Pathologists and Bacteriologists will be held at the University of Wisconsin Medical School, Madison, on April 14 and 15. Headquarters will be the Hotel Loraine.

Contributions to the program are invited; in order that the programs may reach members in suitable time, these should reach the secretary not later than March 4. Cards are available from the secretary's office for the listing of titles, and it is requested that the title card should be accompanied by a brief abstract of not more than 500 words, suitable for publication in the scientific proceedings.

One-half day will be devoted to a consideration of reactive abnormalities of the vascular and supporting tissues with special reference to the collagen diseases. Contributions are also invited to this symposium.

It is hoped that the general program will be a comprehensive covering of the fields of pathologic anatomy, histology and physiology, legal medicine, bacteriology, parasitology, and immunology.

The committee will make no attempt to evaluate the relative merits of papers, and requests that contributors authorize placing titles in the list to be "read by title" if they cannot be included in the program of meetings. In accepting papers, the committee will be guided principally by a desire to group them according to the subject matter or mode of study. By vote of the council, contributions, including illustrative material, must be presented within a limit of ten minutes, except in the case of invited guests.

If contributors wish to make exhibits of materials or methods dealing with the subject of their papers, they are invited to do so through the American and Canadian Section of the International Association of Medical Museums and are requested to notify, as soon as possible, Dr. Ruell A. Sloan, Armed Forces Institute of Pathology, Washington 25, D. C.

Communications regarding contributions and inquiries should be directed to Alan R. Moritz, M. D., Secretary, American Association of Pathologists and Bacteriologists, 2085 Adelbert Road, Cleveland 6, Ohio.

The State Medical Society of Wisconsin

1950 Officers and Committees

President

Dr. J. W. Truitt
161 West Wisconsin Avenue
Milwaukee 3

President-Elect

Dr. H. H. Christofferson
Colby

Secretary

Mr. C. H. Crownhart
704 East Gorham Street
Madison 3

Assistant Secretary

Mr. Roy T. Ragatz
704 East Gorham Street
Madison 3

Treasurer

Dr. I. R. Sisk
1 South Pinckney Street
Madison 3

Speaker, House of Delegates

Dr. W. C. Stewart
Kenosha

Vice-Speaker

Dr. R. L. MacCornack
Whitehall

Councilors*

(Dr. R. G. Arveson, Frederic, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. G. E. Eck, Lake Mills, 1951.

Second: Kenosha, Racine and Walworth County Societies. Dr. T. C. Hemmingsen, 1332 State Street, Racine, 1951.

Third: Dane, Columbia-Marquette-Adams, Green, Rock and Sauk County Societies, Dr. H. Kent, Tenney, 1 South Pinckney Street, Madison, 1952; Dr. H. E. Kasten, 419 Pleasant Street, Beloit, 1951.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1952.

Fifth: Calumet, Manitowoc, Sheboygan and Washington-Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1952.

Sixth: Brown-Kewaunee-Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. A. J. McCarey, 610 Northern Building, Green Bay, 1952.

Seventh: Juneau, La Crosse, Monroe, Trempealeau-Jackson-Buffalo and Vernon County Societies. Dr. J. C. Fox, 508 Batavia Bank Building, La Crosse, 1950.

Eighth: Marinette-Florence, Oconto and Shawano County Societies. Dr. J. M. Bell, Peshtigo, 1950.

Ninth: Clark, Green Lake-Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. H. H. Christofferson, Colby, 1950.

Tenth: Barron-Washburn-Sawyer-Burnett, Chippewa, Eau Claire-Dunn-Pepin, Pierce-St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson (chairman) Frederic, 1950.

Eleventh: Ashland-Bayfield-Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1951.

Twelfth: The Medical Society of Milwaukee County. Dr. R. E. Galasinski, 1227 West Lincoln Avenue, Milwaukee; Dr. T. J. Howard, 706 North Eleventh Street, Milwaukee; Dr. N. J. Wegmann, 2650 West Hopkins Street, Milwaukee, 1951; Dr. D. F. Pierce, Hales Corners, 1952.

Thirteenth: Forest, Langlade, Oneida-Vilas and Price-Taylor County Societies. Dr. J. D. Leahy, Park Falls, 1950.

Dr. Karl H. Doege (Past-President) Marshfield.

Dr. S. E. Gavin, 104 South Main Street, Fond du Lac, Chairman Emeritus.

Delegates to American Medical Association

Dr. S. E. Gavin (1950)
104 South Main Street
Fond du Lac

Dr. J. C. Sargent (1950)
324 East Wisconsin Avenue
Milwaukee 2

Dr. W. D. Stovall (1951)
Service Memorial Institute
Madison 6

Alternates

Dr. L. O. Simenstad (1950)
Osceola

Dr. D. H. Witte (1950)
3405 West Lisbon Avenue
Milwaukee

Dr. D. J. Twohig (1951)
Fond du Lac

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* Map indicating location of councilor districts, page 59.

Standing Committees

Committee on Cancer

Dr. A. R. Curreri, 1952, chairman, 1300 University Avenue, Madison 6
Dr. W. S. Bump, 1950, 1020 Kabel Avenue, Rhinelander
Dr. L. J. Van Hecke, 1950, 231 West Wisconsin Avenue, Milwaukee 3
Dr. T. J. Kroyer, 1950, Walworth
Dr. H. W. Carey, 1950, Lancaster
Dr. D. C. Beebe, 1950, Sparta
Dr. S. L. Henke, 1950, 314 East Grand Avenue, Eau Claire
Dr. J. W. McGill, 1951, 1225 Tower Avenue, Superior
Dr. J. D. Wilkinson, 1951, 110 East Wisconsin Avenue, Oconomowoc
Dr. J. W. McRoberts, 1951, Sheboygan Clinic, Sheboygan
Dr. M. H. Steen, 1951, 19 Jefferson Avenue, Oshkosh
Dr. G. L. McCormick, 1952, 650 South Central Avenue, Marshfield
Dr. K. G. Pinegar, 1952, 1723½ Main Street, Marinette

Advisory Committee on Care of Crippled Children

Dr. H. A. Sincock, 1951, chairman, 1507 Tower Avenue, Superior
Dr. M. H. Steen, 1950, 19 Jefferson Avenue, Oshkosh
Dr. A. B. Schwartz, 1950, 2018 East North Ave., Milwaukee
Dr. C. M. Kurtz, 1951, 1300 University Avenue, Madison 6
Dr. W. P. Blount, 1952, 324 East Wisconsin Avenue, Milwaukee 2
Dr. C. M. Ihle, 1952, 405 Culver Building, Eau Claire

Committee on Coordination of Medical Services

Dr. S. B. Harper, 1950, chairman, 1 South Pinckney St., Madison
Dr. S. E. Gavin, 1951, 104 South Main Street, Fond du Lac
Dr. F. W. Kundert, 1952, 921 Sixteenth Avenue, Monroe
President, ex officio
Secretary, ex officio

Committee on Goiter

Dr. Arnold S. Jackson, 1951, chairman, 16 South Henry Street, Madison 3
Dr. R. E. McDonald, 1950, 425 East Wisconsin Avenue, Milwaukee 2
Dr. T. J. Pendergast, 1952, 161 West Wisconsin Avenue, Milwaukee
Dr. C. N. Neupert, ex officio, State Office Building, Madison 2
Dr. E. S. Gordon, ex officio, 1300 University Avenue, Madison 6

Committee on Grievances

Dr. R. E. Fitzgerald, 1951, chairman, 2218 North Third Street, Milwaukee 12
Dr. E. W. Mason, 1950, 324 East Wisconsin Avenue, Milwaukee 2
Dr. F. A. Nause, 1952, 927 A North Eighth Street, Sheboygan
Dr. C. E. Zellmer, 807½ Fifth Street, Antigo
Dr. E. D. Sorenson, 104 South Wisconsin Street, Elkhorn

Committee on Health and Public Instruction

Dr. E. R. Krumbiegel, 1950, chairman, 608 City Hall, Milwaukee
Dr. Max J. Fox, 1952, 324 East Wisconsin Avenue, Milwaukee 2
Dr. R. C. Parkin, 1952, 1300 University Avenue, Madison

Committee on Hearing Defects

Dr. T. L. Tolan, 1953, chairman, 324 East Wisconsin Ave., Milwaukee 2
Dr. W. E. Grove, 1952, chairman, 324 East Wisconsin Avenue, Milwaukee 2
Dr. G. B. Ridout, 1951, 1836 South Avenue, La Crosse

Committee on Hospital Relations

Dr. A. J. McCarey, 1951, chairman, 610 Northern Building, Green Bay
Dr. M. L. Jones, 1949, 510 Third Street, Wausau
Dr. J. W. Smith, 1949, 1803 North Fifty-Seventh Street, Milwaukee
Dr. R. M. Waters, 1950, 1300 University Ave., Madison 6
Dr. Gorton Ritchie, 1950, 3321 N. Maryland Ave., Milwaukee
Dr. J. E. Habbe, 1951, 231 West Wisconsin Avenue, Milwaukee 3

Committee on Industrial Health

Dr. D. E. Dorchester, 1951, chairman, Sturgeon Bay
Dr. M. L. Jones, 1950, 510 Third Street, Wausau
Dr. E. W. Miller, 1952, 231 West Michigan Street, Milwaukee 3

Committee on Medical Education and Hospitals

Dr. J. K. Trumbo, 1952, chairman, Wausau
Dr. T. L. Squier, 1951, 425 East Wisconsin Avenue, Milwaukee 2
Dr. P. A. Midelfart, 1950, 314 East Grand Ave., Eau Claire
Dr. W. S. Middleton, ex officio, 1300 University Avenue, Madison 6
Dr. J. S. Hirschboeck, ex officio, 561 North Fifteenth Street, Milwaukee 3

Committee on Rural Health and Accident Prevention

Dr. M. W. Stuessy, 1951, chairman, Brodhead
Dr. A. A. Filek, 1950, State Office Building, Madison 2
Dr. R. L. MacCornack, 1952, Whitehall

Committee on Maternal and Child Welfare

Dr. L. M. Simonson, chairman, 1951, 1001 North Eighth Street, Sheboygan
Dr. R. F. Purtell, 1950, 758 North Twenty-Seventh St., Milwaukee
Dr. Amy Louise Hunter, 1950, State Office Building, Madison 2
Dr. J. W. Harris, 1951, 1300 University Avenue, Madison 6
Dr. A. H. Stahmer, 1952, 120½ Clarke Street, Wausau
Dr. Mildred Stone, 1952, 124 North Wisconsin Street, Berlin

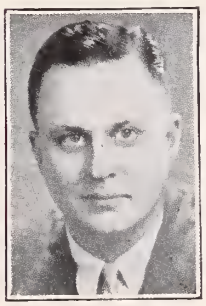
Committee on Mental Hygiene, Institutional Care, Public Welfare, and State Departments

Dr. H. H. Christofferson, 1953, chairman, Colby
Dr. P. R. Minahan, 1950, 110 North Washington Street, Green Bay
Dr. W. A. Munn, 1951, 19 South Main Street, Janesville
Dr. B. J. Hughes, 1952, Winnebago
Dr. E. D. Schwade, 1954, 324 East Wisconsin Avenue, Milwaukee

Committee on Public Policy

Dr. C. A. Dawson, 1953, chairman, River Falls
Dr. S. E. Gavin, 1950, 104 South Main St., Fond du Lac
Dr. J. K. Curtis, 1951, 110 East Main Street, Madison 3
Dr. J. M. Sullivan, 1952, 161 West Wisconsin Avenue, Milwaukee 2
Dr. M. G. Rice, 1952, 401½ Main Street, Stevens Point
President, ex officio
President-elect, ex officio
Secretary, ex officio

Committee on Tuberculosis and Chest Diseases



Dr. J. D. Steele, chairman, 1950, 1705 West Wisconsin Avenue, Milwaukee
Dr. A. A. Pleyte, 1951, 1013 North Jefferson Street, Milwaukee 2
Dr. W. T. Clark, 1952, 317 Hayes Building, Janesville

Committee on Medical Service and Public Relations

Dr. L. O. Simenstad, 1951, chairman, Osceola
Dr. P. M. Currer, 1954, 3122 West North Ave., Milwaukee
Dr. J. S. Supernaw, 1950, 110 East Main Street, Madison
Dr. J. W. McGill, 1952, 1225 Tower Avenue, Superior
Dr. C. R. Marquardt, 1953, 324 E. Wisconsin Ave., Milwaukee
President, ex officio
Past-President, ex officio
Chairman of the Council, ex officio
Speaker of the House, ex officio

Committee on Visual Defects

Dr. J. B. Hitz, 1951, chairman, 411 East Mason Street, Milwaukee 3
Dr. J. K. Trumbo, 1950, 502 Third Street, Wausau
Dr. E. J. Zeiss, 1952, 103 West College Avenue, Appleton

Council on Scientific Work

Dr. J. M. Freeman, 1950, chairman, 406½ Third Street, Wausau
Dr. F. W. Madison, 1951, 425 East Wisconsin Avenue, Milwaukee 2
Dr. W. S. Bump, 1952, 1020 Kabel Avenue, Rhinelander
Dr. T. O. Nuzum, 1953, Janesville
Dr. J. W. Gale, 1954, 1300 University Avenue, Madison
Dr. K. H. Doege, ex officio, Marshfield
Dr. W. S. Middleton, ex officio, 1300 University Avenue, Madison 6
Dr. J. S. Hirschboeck, ex officio, 561 North Fifteenth Street, Milwaukee 3

Advisory Committee to Woman's Auxiliary

Chairman of the Council, chairman
Immediate past-president
President
President-elect
Secretary

COMMITTEES OF THE COUNCIL

(The personnel of these committees will be appointed by the chairman of the Council after the February Council meeting and will be published in a subsequent issue.)

* No terms.

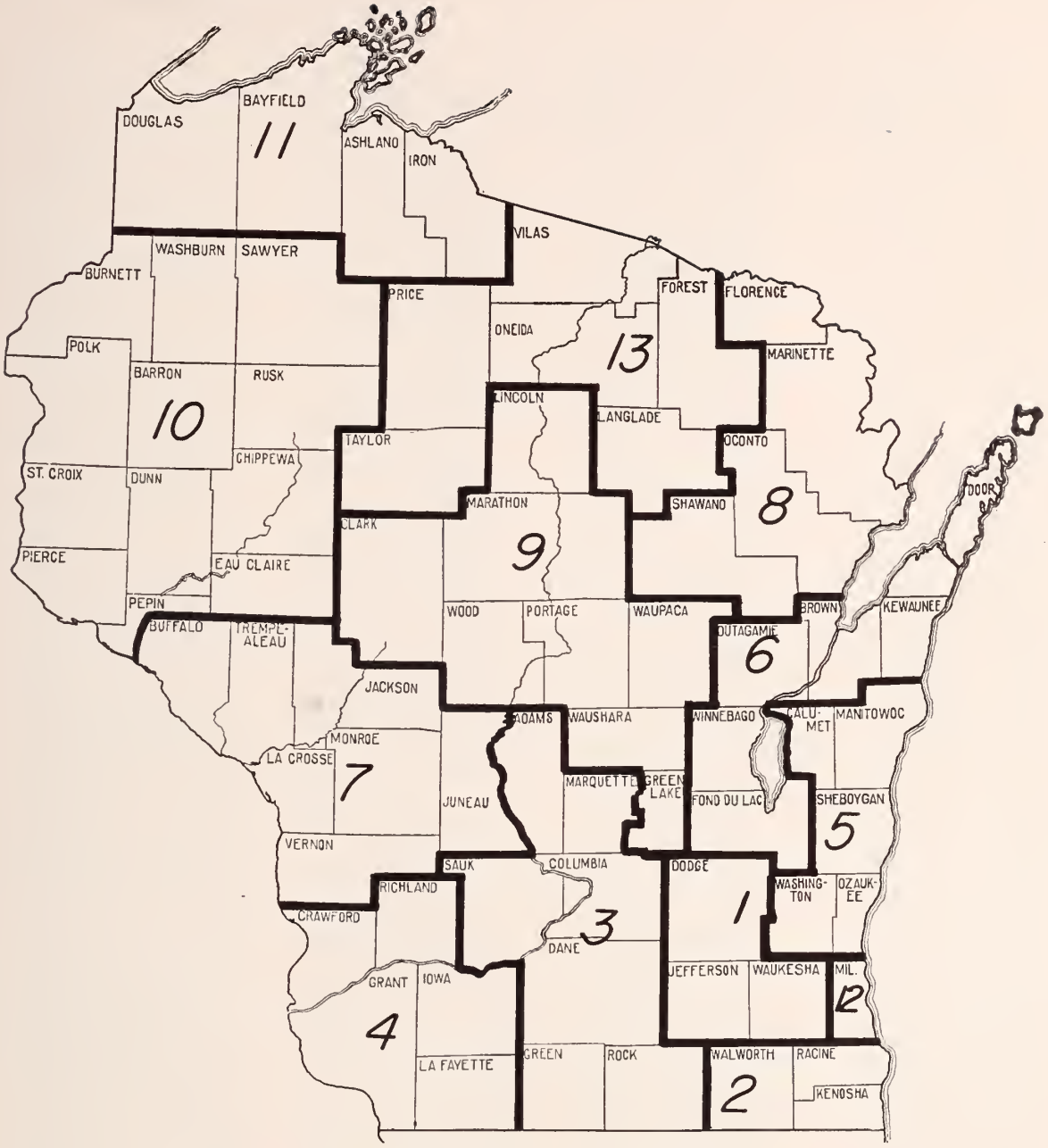
NATIONAL GASTROENTEROLOGICAL ASSOCIATION ANNOUNCES 1950 AWARD CONTEST

The National Gastroenterological Association has announced its annual cash prize award contest for 1950, in which $100 and a certificate of merit will be given for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association; those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges, and the award will be made at the annual convention banquet of the National Gastroenterological Association in October 1950.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of publishing the winning contribution, and those receiving certificates of merit, in its official publication, The Review of Gastroenterology.

All entries for the 1950 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies accompanied by an entry letter, and received not later than June 1, 1950. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.



MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

First District:
Dr. G. E. Eck, Lake Mills

Second District:
Dr. T. C. Hemmingsen, Racine

Third District:
Dr. H. Kent Tenney, Madison
Dr. H. E. Kasten, Beloit

Fourth District:
Dr. E. M. Dessloch, Prairie du Chien

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. A. J. McCarey, Green Bay

Seventh District:
Dr. J. C. Fox, La Crosse

Eighth District:
Dr. J. M. Bell, Peshtigo

Ninth District:
Dr. H. H. Christofferson, Colby

Tenth District:
Dr. R. G. Arveson, Chairman, Frederic

Eleventh District:
Dr. V. E. Ekblad, Superior

Twelfth District:
Dr. R. E. Galasinski, Milwaukee
Dr. T. J. Howard, Milwaukee
Dr. N. J. Wegmann, Milwaukee
Dr. D. F. Pierce, Hales Corners

Thirteenth District:
Dr. J. D. Leahy, Park Falls

Dr. S. E. Gavin, Chairman emeritus,
Fond du Lac

Members, State Medical Society of Wisconsin*

Abbotsford:
Shields, G. G.

Adams:
Ingersoll, B. P.

Adell:
Bemis, I. M.
Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
Pudleiner, H. G.
Witcpalek, W. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Cornwall, W. B.
Dasler, H. A.
Ford, K. K.
Kremser, V. C.

Antigo:
Bloor, E. G.
Curran, W. P.
Donohue, M. J.
Dorzeski, E. F.
Flatley, M. A.
Garbisch, F. H.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Zellmer, C. E.

Appleton:
Adrians, W. A.
Archer, W. E.
Benton, J. L.
Bolton, E. L.
Brooks, E. H.
Carlson, G. W.
Cunningham, P. M.
Dafoe, W. A.
DeCock, R. D.
Dehne, W. O.
Felton, W. C.
Ford, J. L.
Frawley, W. J.
French, G. A.
Gallaher, D. M.
Giffin, W. S.
Gmeiner, J. E.
Gross, H. T.
Haentzschel, L. E.
Harrington, Wm. J.
Hauch, F. M.
Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
MacLaren, J. B.
Marshall, F. S.
Marshall, V. F.
McBain, L. B.
McGrath, E. F.
McNeel, Laird
Mielke, E. F.
Neidhold, C. D.
Pardee, C. A.
Rankin, F. J.
Reeve, J. S.
Schoofs, G. E.
Skibba, J. P.
Swanton, M. E.
Taylor, A. C.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth
Dockendorff, B. C.
Weber, F. T.

*As of December 28, 1949.

Argyle:
Thompson, L. L.

Ashland:
Andrus, A. D.
Bargholtz, W. E.
Butler, Albert
Dodd, J. M., Sr.
Grand, C. A.
Grigsby, R. O.
Harrison, G. W.
Jauquet, J. M.
Kreher, J. E.
Lamal, A. H.
Merrill, W. G.
Prentice, J. W.
Smiles, C. J.
Tucker, W. J.
Weeks, F. D.

Athens:
Bachhuber, G. J.
Bachhuber, H. M.

Augusta:
Moland, O. G.
Thieda, E. S.

Bailey's Harbor
Fillbach, H. E.

Baldwin:
Olson, C. A.
Sargeant, G. M.

Bangor:
Ruppenthal, K. P.

Baraboo:
Cahoon, Roger
Edwards, A. C.
Hannan, K. D. L.
Huth, M. F.
Irwin, H. J.
McGonigle, B. E.
Moon, J. F.
Pearson, C. R.
Sporleder, O. F.
Tryon, F. E.
Vander Kamp, H.

Barron:
Fostvedt, G. A.
Mahaffey, C. H.
Radke, Lucille M.
Smith, R. C.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Clarke, T. C.
Corso, Xavier
Costello, W. H.
Davis, T. C.
Drescher, G. G.
Hoyer, A. A.
Hoyer, E. C.
Hoyer, G. H.
Kores, A. B.
Qualls, C. L.
Roberts, Rob Roy
Rosenheimer, A. M.
Schoen, R. F.
Webb, E. P.
Welsch, J. M.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Allen, W. J.
Brillman, L. P.
Burger, H. E.
Carney, C. M.
Carter, K. L.
Clark, D. M.
Cochrane, W. L.
Crockett, W. W.
Crone, V. D.
Fitzgerald, W. M.
Flarity, T. H.
Fosse, B.
Friend, L. J.
Gunderson, R. H.
Helm, H. M.
Ingersoll, R. S.
John, G. W.
Johnson, F. K.
Kasten, H. E.
Kishpaugh, H. W.
Mauermann, W. J.
McGaughey, C. G.
Ottow, A. F.
Peterson, G. H.
Pollard, W. H., Jr.
Raube, H. A.
Ross, M. E.
Sanderson, R. J.
Shearer, H. A.
Springberg, J. C.
Sweeney, T. C.
Thayer, R. A.
Thompson, I. F.
Vivian, R. S.
Wilson, R. F.

Berlin:
Koch, H. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Stone, Mildred M.
Taugher, V. J.
Wiesender, A. J.

Big Bend:
Boldt, R. E.

Birnamwood:
Damp, O. E.

Black Creek:
Smith, P. W.

Black River Falls:
Drescher, A. A.
Johnson, R. D.
Krohn, Irwin
Krohn, Robert

Blair:
Schnelder, O. M.

Bloomer:
Clauson, C. T.
Hudek, D. F.
Triggs, P. O.

Bloomington:
Edwards, P. K.
Glasier, Mina B.

Bouduel:
Terlinden, J. H.

Boscobel:
Freymiller, E. F.
Hayman, C. S.
McNamee, J. R.
Randall, E. M.
Randall, M. W.

Boulder Junction:
Newcomb, Kate P.

Boyceville:
Williams, A. E.

Brandon:
Lautenbach, E. T.

Brillion:
Dettmann, J. E.
Keller, L. W.
Langmack, W. A.

Brodhead:
Baker, H. P.
Stuessy, M. W.
Swan, F. D.

Brownsville:
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Bennett, J. C.
Bennett, J. F.
Carroll, J. H.
Granzeau, H. W.
Mastalir, L. O.
Mullen, R. A.
Murawsky, W. J.
Newell, F. F.
Sroka, W. C.
Van Liere, J. D.

Cadott:
Zenner, C. E.

Cambridge:
Amundson, K. K.
Bilstad, G. E.

Cameron:
Cronk, C. F.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cato:
Kelley, J. M.

Cedarburg:
Blanchard, P. B.
Hurth, O. J.
Hurth, O. W.
Katz, H. J.

Cedar Grove:
Jensen, J. S.
Van Altena, L. A.
Voskuil, A.

Centuria:
Noyes, G. B.

Chaseburg:
Richter, J. R.

Chetek:
Adams, R. W.
Balken, J. B.

Chilton:
Goggins, J. W.
Humke, E. W.
Humke, K. R.
Knauf, N. J.
Minahan, J. J.
Rathert, E. T.

Chippewa Falls:
Cook, F. D.
Field, Merton
Graber, R. E.
Hatleberg, C. B.
Hatleberg, E. J.
Henske, W. C.
Hunter, H. R.
Janc, W. F.
Kelly, J. A.
Kemper, C. A.
McHugh, F. T.

Picotte, L. W.
Sazama, F. B.
Sazama, J. J.
Williams, S. E.

Clear Lake:
Campbell, L. A.
Campbell, L. A., Jr.

Cleveland:
Feider, A. P.

Clinton:
Thomas, W. O.

Clintonville:
Auld, Irving
German, J. D.
Miller, E. A.
Pfeifer, R. H.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Christofferson, H. H.
Lehmer, R. A.
Schemmer, A. L.

Coleman:
Graner, L. H.

Colfax:
Cooper, C. A.
Felland, O. M.

Columbus:
Caldwell, H. M.
Cheli, C. F.
Mudroch, J. A.
Poser, E. M.
Poser, J. F.
Poser, R. F.

Cornell:
Foster, T. D.

Crandon:
Ison, G. W.
Rathert, B. S.

Cross Plains:
Froggatt, W. E. L.
Lappley, W. F.

Cuba City:
King, C. S.
Terry, R. E.

Cudahy:
Abrams, J. E.
Ackerman, D. S.
Ackerman, E. J.
Fine, J. M.
Kash, S. H.
Krueger, B.
Landsberg, M.
Partridge, C. D.

Cumberland:
Lund, R. E.
Lund, S. O.
Thompson, R. C.

Darien:
Truex, G. O.

Darlington:
McConnell, E. D.
McGreane, N. A.

Deerfield:
Ingwell, C. L.

De Forest:
Carlton, E. P.
Grinde, J. M.

Delafield:
Barnes, H. T.
Olsen, L. C. J.

Delavan:
Crowe, N. F.
Galgano, R. S.
Jacobson, T. L.
Kenney, H. J.
Levin, H. M.
O'Keefe, F. L.
Werbel, H. J.

Denmark:
Hering, G. V.
Michna, C. T.

De Pere:
Elders, W. F.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Hamilton, W. P.
Morton, H. H.
Walker, H. M.

Dorchester:
Foley, F. P.

Dousman:
Notbohm, W. R.
Watry, T. D.

Durand:
Bryant, R. J.
Dittmer, O. A.

Eagle:
Fitzgerald, J. J.
Tempereau, C. E.

Eagle River:
Burnett, C. H.
Colgan, J. J.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Ciccantelli, M. J.
O'Leary, T. J.

Eau Claire:
Anderson, F. G.
Beebe, G. W.
Blom, Julius
Buckley, R. A.
Cameron, W. G.
Dawson, D. L.
Derge, H. F.
Falstad, C. H.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
German, K. L.
Haag, A. F.
Hayes, E. P.
Henke, S. L.
Hilker, A. W.
Huston, H. C.
Ihle, C. M.
Kennedy, R. L.
Kinsman, F. C.
Klein, A. J.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Mautz, W. T.
Mldelfart, Peter
Nester, H. D.
Nezworski, L. G.
Niver, E. O.
Paulson, W. O.
Richards, R. R.
Rosen, T. S.
Russell, S. B.
Schlitter, R. E.
Spelbring, P. G.
Stang, H. M.
Strand, R. C.
Tanner, J. W.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Eden:
Hardgrove, J. H.

Edgar:
Schulz, H. A.

Edgerton:
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shearer, A. T.
Shearer, F. E.
Sumner, W. C.

Elcho:
Dailey, D. W.
Dailey, P. J.

Elkhart Lake:
Martineau, J. E.

Elkhorn:
Bertolaet, E. E.
Bill, K. C.
Helmbrecht, M. G.
Rawlins, J. A.
Sorenson, E. D.
Young, J. H.

Ellsworth:
Aanes, A. R.
Cannon, C. R.

Elm Grove:
Grade, J. O.
Gray, A. W.
Kriz, G. A.
Wheelihan, R. Y.

Elmwood:
Breed, A. L.

Elroy:
Vogel, C. A.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.

Fond du Lac:
Borsack, K. K.
Cerny, F. J.
Connell, John W.
Devine, H. A.
Devine, J. C.
Dockery, E. E.
Finn, W. C.
Flanagan, C. M.
Folsom, W. H.
Gardner, L. C.
Gavin, S. E.
Guth, H. K.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kief, H. J.
Leonard, C. W.
McCormick, D. W.
McCullough, James C.
McCullough, John C.
Meiklejohn, D. V.
Pawsat, E. H.
Schroeder, R. W.
Sharpe, H. R.
Sharpe, J. J.
Simon, L. J.
Smith, E. V.
Smith, E. V., Jr.
Steube, R. W.
Theisen, S. A.
Twohig, D. J.
Twohig, D. J., Jr.
Twohig, J. E.
Vetter, E. W.
Waffle, R. L.
Waldschmidt, W. J.
Walters, D. N.
Wler, J. S.
Wojta, W. C.
Yockey, J. C.

Footville:
Harvey, J. R.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Mallow, H. G. E.
Notbohm, D. R.
Russell, J. C. H.
Venning, J. R.
Young, Will

Fountain City:
Skemp, F. C.

Fox Lake:
Elliott, E. S.

Franksville:
Dockery, J. N.

Frederic:
Andrews, W. C.
Arveson, R. G.
Fischer, W. A.
Moore, R. M.

Fremont:
Arnoldussen, C. P.

Friendship:
Treadwell, G. F.

Galesville:
Alvarez, R. L.
Jegi, H. A.
Rohde, E. P.

Gays Mills:
Boyce, S. R.
Oppert, H. E.
Schott, O. J.

Gillett:
Bailey, D. M.
Berg, W. R.

Gilman:
Cramp, A. L.

Glenwood City:
Limberg, P. W.
McCusker, C. F.

Goodman:
Maginn, R. J.

Grafton:
Pelant, K. F.

Green Bay:
Atkinson, H. S.
Bartran, W. H.
Boersma, J. J.
Bolles, C. S.
Brusky, A. H.
Brusky, E. S.
Burdon, T. S.
Burns, Robert W.
Charbonneau, A. A.
Clark, E. V., Jr.
Clifford, P. M.
Cofrin, D. A.
Cowles, R. L.
Denys, G. F.
Denys, K. J.
Dockry, P. F.
Dredge, T. J.
Dupont, A. J.
Everett, H. H., Jr.
Feig, Milton
Ford, J. L.
Ford, W. W.
Frank, Herbert
Freedman, A. L.
Fuller, M. H.
Goelz, J. R.
Gosin, D. F.
Gosin, F. J.
Griggs, S. L.
Grossman, M. A.
Hagerty, W. T.
Halloin, J. E.
Heitzman, H. H.
Hickey, A. W.
Hitch, O. M.
Icks, K. R.
Jordan, E. M.
Kane, Elizabeth D.
Kaufman, J. E.
Kelly, W. W.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Klspert, R. W
Klobucar, J. J.
Kuehl, F. O.
Kuhs, M. L.

Leaper, W. E.
Levitas, I. E.
McCarey, A. J.
Miller, L. C.
Milson, Louis
Minahan, P. R.
Mokrohijsky, S. M.
Nadeau, E. G.
Nadeau, E. G., Jr.
Nellen, J. W.
Neu, V. F.
Olmsted. A. O.
Painc, E. M.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Saunders, O. W.
Schmidt, E. S.
Schmidt, R. T.
Senn, G. A.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Sullivan, Donel
Tippet, W. P.
Troup, R. L.
Troup, W. J.
Urban, Frank

Green Lake:
Leininger, A. T.

Greendale:
Brown, R. J.
Curtin, J. J.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Pierce, D. F.
Wolf, R. C.

Hartford:
Hoffmann, J. G.
Hoffmann, W. C.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Sachse, F. W.

Hartland:
Bergwall, R. P.
Grover, F. L.
Hansen, R. T.

Hawthorne:
White, E. F., Jr.

Hayward:
Callaghan, D. H.
Krueger, E. R.
Wyant, M. E.

Hazel Green:
Rosmann, H. K.
Strauch, C. B.

Highland:
Erickson, M. T.

Hilbert:
Winkler, R. J.

Hillsboro:
Leuther, P. A.
Sanford, L. L.

Hixton:
Petzke, E. A.

Hollandale:
Marshall, S. B.

Holmen:
Hanson, L. E.

Horicon:
Karsten, J. H.
Lipscomb, T. C.

Hortonville:
Towne, W. H.

Hudson:
Livingstone, J. W.
Newton, J. E.
Nuebel, C. J.

Humbird:
Schwarz, S. G.

Hurley:
Martinetti, D. J.

Hustisford:
Panetti, P. A.

Independence:
Peterson, C. F.
Peterson, D. R.

Iola:
Wiley, R. H.
Wilker, W. F.

Jackson:
Albrecht, J. E.

Janesville:
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Bartels, G. W.
Baumgartner, M. M.
Clark, W. T.
Danforth, H. C.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gutmann, G. E.
Johnson, W. L.
Kelley, J. F.
Klein, T. W.
Koch, V. W.
Llewellyn, M. B.
McGuire, W. H.
Metcalf, G. S.
Munn, W. A.
Nuzum, T. O.
Nuzum, T. W.
Otterholt, E. R.
Overton, O. V.
Pember, A. H.
Pember, J. F.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Schroder, J. R.
Schroeder, J. D.
Snodgrass, H. M.
Snodgrass, T. J.
Steinkopff, E. K.
Tarrasch, Hertha
Thomas, G. L.
Tomlinson, Carol
VanKirk, F. W.
Waufle, G. C.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Garding, C. J.
Quandt, R. W.
Robinson, A. H.

Johnson Creek:
Wendt, F. A.

Junction City:
Reis, G. W.

Juneau:
Heath, H. J.

Kaukauna:
Bachhuber, A. E.
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Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
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Russo, J. G.

Kenosha:
Altman, J. S.
Andre, E. F.
Ashley, R. W.
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Binnie, Helen A.
Block, R. M.
Bode, M. J.
Bowing, I. E.
Coffin, L. E.
Creighton, L. H.
Creswell, C. M.
Davin, C. C.
DeFazio, S. F.
Goldstein, D. N.
Graves, J. P.
Herzog, P. S.
Hill, B. S.
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Kordecki, F. A.
La Macchia, R. M.
Lipman, W. H.
Little, W. W.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Morrow, C. A.
Pearson, J. B.
Pechous, C. E.
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Powell, R. A.
Randall, A. J.
Rauch, A. M.
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Richards, C. G.
Rufflo, A. F.
Schlapik, A.
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Schwartz, G. J.
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Siegel, Morris
Stewart, W. C.
Ulrich, C. F.
Williams, F. C., Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
Nesemann, R. M.
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Wochos, W. M.

Kiel:
Nauth, D. F.
Twohig, G. J.

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Maes, C. G.

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Montgomery, R. C.

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Bruder, V. F. J.
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Davies, May A.
Dietz, P. C.
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Doyle, D. F.
Eagan, R. L.
Egan, J. F.
Eidam, L. W.
Ernst, F. W.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Gatterdam, P. C.
Gilbert, R. L.
Gorenstein, L. M.
Gray, R. H.
Gundersen, A. H.
Gundersen, Gunnar
Gundersen, S. B.
Gundersen, T. E.
Haines, B. J.
Harman, J. C.
Harris, H. W.
Heraty, J. E.
Hulick, P. V.
Jones, W. J.
Kelly, C. M., Jr.
Mansheim, B. J.
McGarty, M. A.
Midelfort, C. F.
Mueller, J. J.
O'Meara, M. T.
Parkin, E. M.
Phillips, P. W.
Reay, G. R.
Ridout, G. B.
Satory, J. J.
Schaefer, Margaret A.
Schmidt, L. R.
Sevenants, J. J.
Simones, J. J.
Sivertson, Martin
Skemp, A. A.
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Smith, D. S.
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Townsend, E. H.
Uhrich, G. I.
Weidner, G. L.
Wolf, F. H.
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Bauer, D. F.
Bauer, W. B. A.
Lundmark, L. M.
Murphy, J. E.
Pagel, H. F.
Smith, Woodruff

La Farge:
Gollin, F. F.

Lake Geneva:
Bischof, H. F.
Brady, C. J.
Clark, W. S.
Halsey, R. C.
Hudson, E. D.
Jeffers, D. H.
MacDonald, W. H.

Lake Mills:
Eck, G. E.
Leicht. Phillip
Netzow, E. J.
Peterson, M. G.
Schoenecker, E. A.
Turcott, R. A.

Lancaster:
Carey, H. W.
Fowler, J. H.
Glynn, J. D.
Houghton, E. M.
Hudson, L. A.
Kraut, Elgie
Matthiesen, D. E.

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Eickhoff, E. C.

Laona:
Carroll, G. E.
Castaldo, E. F.
Ovitz, E. G.

LaValle:
Booher, J. A.

Lena:
Rose, J. F.

Little Chute:
Curtin, D. W.
Gage, R. S.
Verbrick, W. C.

Lodi:
Groves, R. J.
Irwin, G. H.
Irwin, W. G.

Loganville:
Jewell, E. L.

Lomira:
Fuller, J. D.
Luxemburg
Jandrain, R. R.

Madison:
Aageson, C. W
Albright, E. C.
Alderfer, H. H.
Allin, R. N.
Angevine, D. M.
Apell, M. G.
Ashman, H. C.
Atwood, D. C.
Baehr, L. T.
Bardeen, Ann
Battle, W. D.
Baumeister, Max, Jr.
Becker, D. B., Jr.
Bell, P. P.
Bennett, Maxine
Bentley, J. E.
Berger, J. V., Jr.
Betlach, Dorothy W.
Bleckwenn, W. J.
Bleyer, L. F.
Boner, A. J.
Briggs, S. J.
Brindley, B. I.
Britton, D. M.
Brodhead, R. H.
Brown, J. W.
Bruskewitz, H. W.
Bryan, A. W.
Burke, C. F.
Burke, Mead
Burke, Myra E.
Burke, S. S.
Burns, E. M.
Burns, R. E.
Calvert, Charlotte
Cameron, Eugenia S.
Campbell, R. E.
Carns, Marie L.
Carter, H M
Chase, S. L.
Clausen, N. M.
Collier, E. J.
Collins, R. F.
Cooksey, R. T.
Coon, H. M.
Cooper, G. A.
Cullander, C. C. H.
Curreri, A. R.
Curtis, J. K.
Davis, A. W.
Davis, F. A.
Davis, Helen P.
Dean, F. K.
Dean, J. C.
Dean, J. L.
Dean, J. P.
Dickie, H. A.
Dieter, D. G.
Dimond, W. B.
Doermann, E. L.
Dollard, J. E.
Domine, A. Z.
Doolittle, J. W.
Duehr, P. A.
Ellis, I. G.
Embick, R. P.
Erickson, T. C.
Evers, R. H.
Ewell, G. H.
Falk, V. S.
Fauerbach, L.
Fike, F. A.
Filek, A. A.
Fitch, Edna M.
Fosmark, C. A.
Foster, M. A.
Foster, Ruth C.
Frankenstein, N. A.
Gale, J. W.
Gallagher, J. T. F.
Ganser, W. J.
Gearhart, R. S.
Geist, F. D.
Geppert, T. V.
Gilmore, W. E.
Glover, B. H.
Golden, P. B.
Golper, M. N.
Gonce, J. E., Jr.
Gordon, E. S.
Green, R E.
Greene, H. L.
Grimstad, Frances H.
Grumke, E. H.
Guilford, H. M.
Haley, H. B.
Hank, G. C.
Harper, C. A.
Harper, C. S.
Harper, S. B.
Harris, J. W.
Hayworth, Ballard
Healy, W. G.
Helland, N. J.
Hennen, R. J.
Hibma, O. V.
Hill, N. A.
Hobbins, W. B.
Hogan, L. H.
Holmgren, L. E.
Hummer, F. L.
Hunter, Amy Louise
Hurlbut, J. A.
Iams, A. M.
Jackson, A. S.
Jackson, J. A.
Jackson, R. H.
Jaeschke, W. H.
Jarvis, E. C.
Joachim, F. G.
Johnson, H. C.
Johnson, S. A. M.
Jorris, E. H.
Juhl, J. H.
Juster, E. M.
Kant, Fritz
Kay, H. M.
Kincaid, C. K.
Kolman, I. E.
Krehl, W. H.
Kundert, P. R.
Kurtz, C. M.
Kurtz, E. C.
Lacke, C. L.
Laird, Anna K.
Lemmer, G. N.
Lemmer, K. E.
Leonard, T. A.
Lindsay, W. T.
Littig, L. V.
Lorenz, W. F.
Ludden, R. H.
MacGregor, J. K.
Mac Kay, A. M.
Mailer, A. R.
Malec, J. P.
Maloney, F. G.
Maloof, G. J.
Marsden, W. H.
Masten, M. G.
McCormick, S. A.
McDonough, K. B.
McGary, Lester
McIntosh, J. F.
McIntosh, R. L.
Meanwell, W. E.
Mendenhall, J. T.
Meyer, O. O.
Middleton, W. S.
Miller, J. E.
Mohs, F. E.
Moore, J. C.
Moore, J. D.
Moore, W. J.
Musser, M. J., Jr.
Nelson, P. D.
Nereim, T. J.
Nesbit, M. E.
Nesbit, W. M.
Neupert, C. N.
Newman, J. R.
Nordby, E. J.
Nugent, M. E.
Okagaki, H. I.
Oosterhous, G. E.
Orth, O. S.
Parkin, R. C.
Parks, H. K.
Paul, L. W.
Paulson, J. F.
Peters, H. A.
Pohle, E. A.
Prouty, Margaret
Puestow, K. L.
Quisling, A. A.
Quisling, G. D.
Quisling, R. A.
Quisling, Sverre
Ramlow, R. W.
Reese, H. H.
Remley, A. R.
Reznichek, C. G.
Robbins, J. H.
Roemer, E. P.
Rogers, S. C.
Rowe, M. E.
Rupe, L. O.
Sarfatty, I. J.
Sauthoff, August
Schafer, Etheldred L.
Schmidt, E. R.
Schmitz, R. C.
Schneiders, E. F.
Schoenenberger, A. P.
Schroeder, C. F.
Schubert, C. K.
Schuele, D. T.
Schwei, G. P.
Schwittay, Addie M.
Sencer, Walter
Shapiro, H. H.
Sherman, C. F.
Shumate, J. K.
Sims, J. L.
Sinaiko, R. P.
Sisk, I. R.
Smith, M. M.
Soucek, Adolph
Sprague, J. T.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
Stehr, A. C.
Steinhaus, J. E.
Stolberg, C. A.
Stoops, C. W.
Stovall, W. D.
Straughn, R. A.
Suckle, H. M.
Sullivan, A. G.
Sullivan, E. S.
Supernaw, J. S.
Taborsky, C. R.
Tanner, W. A.
Tatum, A. L.
Taylor, F. B.
Tenney, H K.
Thelen, Christine
Thomas, N. G.
Thornton, M. J.
Tormey, A. R.
Tormey, T. W.
Trautmann, Henry
Tweeten, J. K.
Urben, W. J.
Van Duser, A. L.
Van Gemert, J. G.
Vingom, C. O.
Waddell, J. G.
Washburne, A. C.
Waskow, W. L.
Waters, D. D.
Wear, J. B.
Weinstein, A. B.
Welke, E. G.
Werrell, W. A.
Weston, F. L.
Wheeler, R. M.
Wilkie, J. M.
Williams, D. L.
Wirig, M. H.
Wirka, H. W.
Wochos, R. G.
Wylde, R M.
Young, W. P.
Zintek, A. R.
Zupanc, Edward

Manawa:
Haman, K. L.

Manitowoc:
Andrews, M. P.
Belson, H. J.
Bonner, N. A.
Donohue, W. E.
Erdmann, N. C.
Gregory, L. W.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Koon, W. D.
MacCollum, C. L.
Radl, C. J.
Randolph, R. C.
Randolph, W. C.
Rau, G. A.
Rauch, W. A.
Rees, T. H.
Schaefer, H. E.
Scherping, W. H.
Simenson, R. S.
Simon, G. M.
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Stueck, A. F.
Teitgen, Arthur
Teitgen, T. A.
Turgasen, F. E.
Wall, C. E.
Yost, R. G.

Marathon:
Kampine, C. E.

Marlbel:
May, J. H.

Marinette:
Boren, C. H.
Boren, Clark H.
Boren, J. W., Jr.
Duer, G. R.
Jorgenson, H. L.
Koepp, C. E.
May, J. V.
McCanna, P. R.
Moss, K. J.
Nadeau, A. T.
Pinegar, K. G.
Schroeder, H. F.
Shaw, R. W.
Simms, D. M.
Zeratsky, J. D.

Marion:
Schwab, R. L.
Van Schaick, R. E.

Markesan:
Cupery, D. P.
Pelton, R. S.

Marshfield:
Baldwin, R. S.
Boeckman, F. A.
Christofferson, J. W.
Copps, L. A.
Custer, G. S., Jr.
Dick, L. A.
Doege, K. H.
Doege, P. F.
Epstein, Stephan
Gouze, F. J.
Hipke, Wm.
Lewis, R. F., Jr.
Mason, R. W.
McCormick, G. L.
McGinn, E. J.
Miale, J. B
Millard, A. L.
Miller, G. E.
O'Connor, W. B.
Potter, R. P.
Vedder, C. A.
Vedder, J. S.
Wickham, J. M.
Wink, R. H.

Mauston:
Griffin, V. M.
Hess, J. S.
Tverberg, M. S.
Vedner, J. H.

Mayville:
Bachhuber, F. G.
Parish, G. A.

Mazomanie:
Schultz, I.

Medford:
Eivis, E. B.
Meyer, W. W.
Nystrum, L. E.
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Mellen:
Lockhart, C. W.

Melrose:
Lavine, I. H.

Menasha:
Corry, L. F.
Forkin, G. E.
Foseid, O. F.
Hildebrand, G. B.
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Jensen, F. G.
Jensen, R. A.
Nebel, J. R.
O'Brien, P. T.
Pratt, G. N., Jr.

Menomonee Falls:
Baugh, C. W.
Burkhardt, E. W.
Domann, W. G.
Hoyt, G. E.
Schloemer, A. J.

Menomonie:
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Buckley, C. H.
Grannis, I. V.
Halgren, J. A.
Long, D. T.
Lumsden, Wm.
McMahon, A. E.
O'Neill, J. W.
Quilling, P. A.
Steves, B. J.

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Ashe, H. S.
Kleinboehl, J. W.

Merrill:
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Kelley, F. H.
Lane, F. C.
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Morris, K. A.
Ravn, Bjarne
Ravn, E. O.

Merrillan:
Mitchell, D. G.

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Milltown:
Hohf, A. H.

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Davis, M. D.

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Allen, L. L.
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Ansfield, D. J.
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Apfelberg, H. J.
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Arduino, L. J.
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Arneth, J. J.
Arnold, W. G.
Aszman, P. E.
Ausman, D. C.
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Avellone, B. M.
Avery, H. F.
Aylward, T. J.
Babbitt, D. P.
Babbitz, A. L.
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Babby, Louis
Bach, E. C.
Bach, M. J.
Bach, R. J.
Bachhuber, E. A.
Backus, E. A.
Baier, A. R.
Baker, V. L.
Baldi, J. B.
Baldigo, E. M.
Bardenwerper, H. E.
Barnes, J. S.
Barrock, J. J.
Barta, E. F.
Bauch, N. G.
Bauer, C. A.
Bauman, R. O.
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Baumgart, C. H.
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Bechmann, Fred
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Bederman, S. S.
Behnke, E. J.
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Belknap, E. L.
Bellehumeur, C. E.
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Benjamin, H. B.
Bensman, L. L.
Benton, R. W.
Bercey, J. E.
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Berner, C. L.
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Zurhelde, H. O.

Mineral Point:
Hohler, E. J.
Ludden, H. D.
Ridley, S. R.
White, C. L.

Minocqua:
Huber, G. W.
Savory, P. B.
Sprague, J. P.

Mishicot:
Skwor, C. J.

Mondovi:
Gillette, F. J.
Johnson, B. F.
Mohler, G. T.
Sharp, D. S.
Walker, J. P.

Monroe:
Barry, G. R.
Baumle, C. E.
Bear, N. E.
Bear, W. G.
Brunkow, B. H.
Creasy, L. E.
Fencil, W. J.
Gnagi, W. B., Jr.
Kindschi, L. G.
Kundert, F. W.
Leiser, A. E.
Marbry, G. W.
Mings, D. E
Moore, L. A.
Peters, E. E.
Ruehlman, D. D.
Schindler, J. A.
Snowden, P. W.
Weir, J. R.

Monticello:
Benkendorf, Charles

Montello:
Federman, E. H.
Inman, R. F.

Montfort:
Rasmussen, N. G.

Montreal:
Baird, H. D.
Pierpont, J. M.

Mosinee:
Hoessel, A. W.
Jackson, J. A.
Knoedler, W. A., Jr.

Mount Calvary:
Miller, J. F.

Mount Horeb:
Buckner, H. M.
Morrison, M. T.

Mukwonago:
Holland, H. J.
Voellings, W. J.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Kelm, G. J.

Neenah:
Anderson, G. R.
Beglinger, H. F.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Graham, A. P.
Henning, Laura E.
Henning, R. E.
Jenk, L. F.
Pansch, F. N.
Petersen, G. W.
Pitz, M. N.
Quade, R. H.
Regan, D. M.
Smith, F. H.
Smith, T. D.
Williamson, G. H.

Nellisville:
Frank, H. A.
Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
Rosekrans, Sarah D.

Nekoosa:
Backus, O. A.
Pomainville, H. G.
Werner, W. A.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J. A.
Hicks, E. V.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Starnes, Brand

New London:
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

New Richmond:
Armstrong, J. H.
Campbell, Douglas
Drury, E. M.
Epley, O. H.
Healy, J. P.

Niagara:
Lamb, R. F.
McCormack, E. A.

North Lake:
Donnelly, F. J.

Norwalk:
Allen, J. S.

Oconomowoc:
Feasler, C. H.
Hassall, J. C.
James, W. D.
Loughnan, A. J.
Love, G. R.
Nammacher, T. H.
Rogers, A. F.
Stemper, I. T.
Taylor, C. W.
Theobald, P. B.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, M. R.
Wilkinson, P. M.

Oconto:
Aageson, H. A.
Slaney, A. F.
Zantow, F. E.

Oconto Falls:
Goggins, R. J.
Rauchschwalbe, L. E.
Robinson, T. N.

Ogema:
Rinehart, B. M.

Omro:
Schoenbechler, L. J.

Onalaska:
Reay, G. D.

Oneida:
Minoka-Hill, Lillie R.

Ontario:
Devine, G. C.

Oregon:
Johnson, E. S.
Kellogg, L. S.
Roisum, B. H.

Orfordville:
McNair, E. R.

Osceola:
Simenstad, L. O.
Weller, L. J.

Oshkosh:
Beatty, S. R.
Behnke, C. H.
Bitter, R. H.
Clark, Burton
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, H. J.
Danforth, Q. H.
Ebert, R. O.
Emrich, P. S.
Gerth, R. E.
Graber, L. D.
Graiewski, S. J.
Greenwood, B. S.
Guenther, V. G.
Haines, M. C.
Haubrick, H. J.
Heise, L. F.
Helmes, L. O.
Hugo, D. G.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Lelbenson, S. J.
Linn, W. N.
Lockhart, J. W.
Lynch, G. V.
Mellicke, C. A.
Meli, J. V.
Mendez, A. A.
Meusel, H. H.
Pfefferkorn, E. B.
Romberg, H. A.
Schein, J. E.
Steele, G. A.
Steen, M. H.
Strauser, E. R.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.

Osseo:
Knutson, O.
Leasum, R. N.

Pardeeville:
Gillette, H. E.
Winkler, H. A.

Park Falls:
Leahy, J. D.
Leahy, J. J.
Lohr, W. H.
Murphy, J. L.

Pepin:
Belitz, A. E.
Hogan, John

Peshtigo:
Bell, J. M.
Haasl, H. W.

Pewaukee:
Egloff, L. W.
Kelly, J. P.
Samuelson, Clarence

Phelps:
Schmitt, R. W.

Phillips:
Niebauer, W. E.
Norviel, H. B.
Rens, J. L.
Van Hecke, D. S.

Pittsville:
Beyer, Hart

Platteville:
Andrew, C. H.
Bair, G. W.
Cunningham, Wilson
Doeringsfeld, H. L.
Moffett, J. L.
Soles, F. A.
Wheeler, C. H. E.

Plum City:
Steiger, E. E.

Plymouth:
Brickbauer, A. J.
Delcher, H. F.
Koop, C. S.
Muelier, J. F.
Radloff, A. C.
Steffan, L. J.

Portage:
Harkins, J. P.
Henney, C. W.
Jones, W. W.
MacGregor, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.

Port Edwards:
Bigford, W. D.

Port Washington:
Barr, A. H.
Kauth, C. P.
Savage, G. F.
Stein, C. C.
Walsh, J. F.

Potosi:
Kelly, W. J.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.
Stevenson, D. J.

Poy Sippi
Stimpson, G. C.

Prairie du Chien:
Dessioch, E. M.
Epley, V. C.
Farrell, T. F.
Kleinpell, H. H.
Satter, O. E.
Shapiro, H. L.

Prairie du Sac:
Trautmann, Milton

Prescott:
Laney, H. J.

Princeton:
Theiler, A. C.

Pulaski:
Brusky, S. F.
McDermott, J. F.
Shippy, V. J.

Racine:
Albino, J. M.
Barina, H. J.
Bennett, W. H.
Bliwas, Arnold
Brehm, H. G.
Brehm, H. J.
Buckley, W. E.
Burch, V. J.
Christensen, F. C.
Christenson, C. W.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
Docter, J. C.
Edwards, A. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Gettelman, S. T.
Gillett, G. N.
Grinney, June L.
Grinney, L. R.
Hanson, W. C.
Hemmingsen, T. C.
Henken, J. F.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Jamieson, J. G.
Jones, Beatrice O.
Kadin, Maurice
Kehl, K. C.
Keland, H. B.
Kline, C. L.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Kurten, R. M.
Lehner, R. H.
Lifschutz, L. M.
Lindner, A. M.
Low, N. L.
Marek, F. B.
Miller, H. C.
Nelson, A. J.
Nickelsen, J. R.
Olson, E. S.
Padorr, M. P.
Peterson, R. O.
Pfeifer, E. C.
Pfeiffer, A. S.
Pfeiffer, O. W.
Pitts, Eugene
Pope, F. W.
Postorino, J. D.
Rodick, J. C.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schaefer, C. O.
Schatz, W. R.
Scheible, F. J.
Schenkenberg, Grace E.
Schneiler, E. J.
Schnetz, L. N.
Schuster, Myron
Skow, G. D.
Smullen, G. H.
Thackeray, R. C.
von Buddenbrock, E.
von Jarchow, B. L.
Walter, G. W.
Walters, H. G.
Wier, F. A.
Williamson, W. H.
Wright, R. S.

Randolph:
Horvath, D. C.
Jones, A. W.

Random Lake:
Malloy, T. E.
Russell, J. A.

Reedsburg:
Hanko, J. E.
Pawlisch, O. V.
Rouse, J. J.
Stadel, E. V.

Reedsville:
Cary, E. C.

Rhinelander:
Bump, W. S.
Cline, Frances A.
Gager, W. F.
Harter, A. F.
Haug, T. M.
Jarvis, D. F.
Komasinski, V. W.
Larrabee, W. F., Jr.
Richards, C. A.
Schiek, I. E.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Eidsmoe, N. A.
Johnson, A. G.
Maser, J. F.
Rydell, O. E.
Rydell, W. B.
Vaudreuil, W. F.

Richfield:
Kern, T. J.

Richland Center:
Benson, G. H.
Borgerson, R. J.
Duil, C. F.
Edwards, W. C.
Hinke, D. H.
Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, B. I.
Pippin, L. M.
Sholtes, C. A.
Taft, D. J.

Rio:
Maas, W. C.
Pease, W. A.

Ripon:
Bachus, A. C.
Barnes, E. C.
Cole, D. F.
Johnson, J. M.
La Ham, J. T.
O'Neal, Orvil
Schuler, W. H.
Watson, E. L.

River Falls:
Cairns, R. U.
Davee, Chalmer
Dawson, C. A.
Gutzler, P. H.
McJilton, C. E. J.
Peterson, C. C.

Rosendale:
Scheid, M. M.

Rosholt:
Benn, V. A.

St. Croix Falls:
Riegel, F. B.
Riegel, G. S.
Riegel, J. A.

Sauk City:
Bachhuber, H. A.
Walsh, T. W.

Sawyer:
Olsen, W. J.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sleb, L. H.

Sharon:
Schrock, J. B.

Shawano:
Arvold, D. S.
Bauer, Frederick
Cantwell, A. A.
Cantwell, R. C.
Henke, F. W.
Jeffries, D. A.
Marsh, H. C.
Peterson, L. W.
Rivard, R. R.
Schutz, W. J.
Sebesta, A. J.

Sheboygan:
Bassewitz, P. P.
Bock, A. B. C.
Duckering, Florence A.
Eckardt, B. F.
Eigenberger, F.
Gruenwald, Ludwig
Gunther, T. J.
Heiden, H. H.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Holman, A. M.
Hougen, E. T.
Huibregtse, W. G.
Juckem. G. J.
Junck, J. A.
Keane, K. M.
Knauf, A. J.
Kohler, H. H.
Kolb, F. K.
Kovacic, J. F.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Moir, Jane M.
Moir, W. W.
Nause, F. A., Jr.
Nause, F. P.
Neumann, W. H.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Schmitt, A. J.
Schott, E. G.
Simonson, L. M.
Simpson, R. M.
Sonnenburg, W. M.
Squire, C. A.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Van Zanten, Wesley W.
Weber, C. J.
Winsauer, H. J.
Zaegel, R. L.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Pfeiler, A. G.
Weisch, R. G.

Shell Lake:
Davis, R. R.
Moen, D. V.

Shiocton:
LaCroix, G. M.

Shullsburg:
Hoesley, H. F.

Silver Lake:
De Witt, C. A.

Sister Bay:
Davis, N. S., Jr.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

Solon Springs:
Wilcox, A. G.

South Milwaukee:
Crigier, R. R.
Dempsey, G. P.
Flaherty, G. S.
Grimm, J. J.
Oberfeld, H. H.
O'Leary, W. J.
Schmitz, J. T.

Sparta:
Beebe, D. C.
Beebe, S. D.
Flynn, R. A.
Harris, A. J.
Mannis, Harry
Scantleton, J. M.
Williams, H. H., Jr.

Spencer:
Callahan, H. T.

Spooner:
Olson, L. J.
Sahs, M. H.
Van Ells, L. A.

Spring Valley:
Conway, H. P.
Conway, J. M.
Hill, E. F.

Stanley:
LaBreche, J. J.
Mathwig, R. J.
Overgard, A. W.

Star Prairie:
Perrin, H. E.

Statesan:
Schmidt, R. H.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Cowan, W. F.
Crosby, E. P.
Dunn, A. G.
Gehin, F. E.
Gramowski, W. A.
Iber, F. C.
Kidder, E. E.
Litzow, J. A.
Marrs, F. A.
Miller, S. R.
Rice, M. G.
Sanders, R. H.
Sheehan, W. C.
Slater, R. H.
Sowka, P. N.
Wisiol, Erich

Stockbridge:
Knauf, J. A.

Stoughton:
Nordholm, V. W.
Peterson, R. K.
Schoenbeck, R. F.
Smedal, A. T.

Stratford:
Kroeplin, F. C.

Strum:
Henry, E. W.

Sturgeon Bay:
Beck, J. G.
Dorchester, D. E.
Grota, H. D.
Huff, F. C.
Muehlhauser, J. O.
Pinney, J. C.

Sturtevant:
Peehn, F. G.

Sun Prairie:
Grab, J. A.
Nelson, E. J.
Peterson, L. W.
Russell, W. T.

Superior:
Anderson, R. T.
Beebe, L. W.
Carpenter, E. E.
Christianson, H. B.
Doyle, T. J.
Droege, C. T.
Easton, J. W.
Ekblad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Charles W.
Giesen, Conrad W.
Jackson, R. C.
Johnson, F. G., Jr.
Kyilo, J. C.
Lavine, M. M.
McGill, J. W.
Meyers, J. M.
Myers, E. A.
Perrin, S. H.
Picard, C. J.
Reibold, F. W.
Searle, D. R.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.
Weisberg, J. H.

Suring:
Dougherty, J. S.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.
Langenfeld, P. F.

Thiensville:
Eibe, T. D.
Scholz, H. F.

Thorp:
Jorgensen, Eleanora F.
Jorgensen, P. B.
Neis, F. P.

Three Lakes:
Palmer, B. F.

Tigerton:
Gates, A. J.

Tomah:
Hovda, A. A.
Kozarek, C. E.
Mubarak, J. S.
Scheurich, L. G.
Winter, A. E.

Tomahawk:
Baker, G. R.
Baker, R. G.
McCormick, W. C

Two Rivers:
Kozelka, A. W
Marshall, W. S.
Martin, R. E.
Pick, D. M.
Weld, S. L.
Zlatnik, A. P.

Turtle Lake:
Halberg, A. C.

Union Grove:
Haedike, W. D.
McCracken, R. W.
Schulz, G. J.

Valders:
Huth, E. W.

Verona:
Weiland, H. P.

Viola:
Meboe, Joseph

Viroqua:
Ender, C. A.
Gulbrandsen, L. F
Gulbrandsen, L. O.
Hirsch, R. S.
Hoff, A. D.
Kuehn, A. E.

Wabeno:
Tenley, O. S.

Walworth:
Coon, W. W.
Kroyer, T. J.

Washburn:
Guzzo, Harold

Waterford:
Dietz, R. J.
Malone, F. A.

Waterloo:
Allen, S. C.
Kennedy, F. H.
Schmidt, C. W.

Watertown:
Abelmann, T. C. H.
Becker, W. C.
Bowen, E. W.
Burzynski, E. E.
Dierker, O. F.
Hahn, A. C.
Kosanke, F. E.
Miller, E. A.
Nickels, A. C.
Nowack, L. H.
Nowack, L. W.
O'Toole, J. J.
Waite, W. S.
Welbourne, R. P.
Zimmerman, F. H.

Waukesha:
Bartos, J. A.
Brown, W. E.
Campbell, P. E.
Campbell, W. B.
Davies, E. B.
Davies, Gwilym
Edmondson, C. C.
Frick, J. C.
Gantz, H. A.
Gecht, E. A.
Grosskopf, E. C.
Hawley, R. L.
Houston, H. S.
Longley, B. J.
Promer, J. E.
Scheele, F. M.
Schlossman, N. C
Seno, Elvira C.
Settlage, H. A.
Sydow, H. F.
Thompson, F. A.
Tibbitts, U. J.
Werra, B. J.
Werra, M. J
Wiley, C. E.
Williams, A. J.
Wood, C. A.
Zietlow, F. G.

Wannakee:
Marquis, W. R.

Waupaca:
Boudry, M. O.
Breckenridge, H. E.
Christofferson, A. M.
Patterson, L. G.
Salan, Sam
Steiner, J. H.

Wanpun:
Hebenstreit, A. J.
Hull, H. H.
Klepfer, J. F.
Petters, W. J.
Reslock, C. P.
Schmidt, E. A.
Schrank, L. W.
Schrank, R. E.
Semmens, J. P.
Swartz, K. A.

Wausau:
Arnold, J. H.
Becker, W. T.
Brick, E. B.
Burek, A. W.
Christensen, H. W.
Davis, Helen Crawford
Fechtner, H. H.
Fehland, H. R.
Flannery, J. V.
Flemming, E. E.
Flemming, N. E.
Foerster, J. M.
Freeman, J. M.
Frenzel, W. C.
Green, D. M.
Hammes, G. R.
Hendrickson, A. O.
Hendrickson, W. O.
Johnson, F. C.
Jones, M. L.
Keiley, O. R.
Larsen, R. B.
Ludwig, E. P.
Miller, W. C.
Prehn, F. C.
Rounds, W. M.
Schroth, G. J.
Shannon, R. C.
Smith, J. F.
Smith, S. M. B.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
Trumbo, J. K.
Wilson, O. M.

Wautoma:
Beck, A. A.
Darby, R. C.
Wright, C. A.

Wauwatosa:
Banyai, A. L.
Beck, K. H.
Bowden, R. H.
Buhl, T. L.
Cadden, A. V.
Chandler, W. W.
Clanton, E. L.
Clasen, E. A.
Coffey, W. L., Jr.
Cordes, V. J.
Dallwig, E. L.
Daniels, E. R.
Danziger, Lewis
Dettmann, N. F.
Deysach, L. J.
Donath, L. H.
Efron, Joseph
Fellows, R. M.
Fifrick, L. L.
Gates, J. F.
Glienke, C. F.
Gutheil, D. A.
Hall, R. W.
Hershberg, R. A.
Howard, M. Q.
Janney, F. R.
Kasak, Michael
Kehlnhofer, F. H.
Kindwall, J. A.
Kocovsky, C. J.
Koepsell, J. E.
Kradwell, W. T.
Kuzma, J. F.
La Susa, T. J.
Leifert, K. A.
McCreary, W. K.
Means, J. A.
Morrison, R. C.
Murphy, T. R.
Norum, H. A.
Orr, C. P.
Osgood, C. W.
Peterson, E. F.
Pisciotta, A. V.
Puchner, T. C.
Radke, R. W.
Rettig, F. E.
Sakaguchi, S. S.
Sargeant, H. W.
Schmit, Felix
Schoene, F. C.
Schubert, E. F.
Seifert, K. A.
Seymer, L. A.
Stranberg, W. L.
Winters, K. J.
Worm, G. J.
Wynegar, D. E.

Webster:
Maas, D. A.

West Allis:
Aguirre, M. R.
Beffel, J. M.
Brumbaugh, E. V.
Collins, E. G.
Couch, T. T.
Dohearty, W. H.
Everts, E. L.
Frederick, R. H.
Fulton, J. W.
Grabieck, M. V.
Heinan, F. C.
Hermann, W. C.
Hoffman, G. T.
Hugo, G. J.
Klopfer, W. P.
Malensek, M. C.
McMurry, O. R.
Nefches, M. S.
Nimz, F. N.
Ohlsen, M. P.
Olson, C. R.
Paver, R. L.
Smits, R. H.
Stamm, M. P.
Steckler, Armin
Stern, C. S.
Stern, L. S.
Toepfer, R. A.
Twelmeyer, H. F.
Wilkinson, E. D.
Wilkinson, J. J.

West Bend:
Bauer, K. T.
Bernhardt, E. L.
Bush, F. I.
Driessel, R. H.
Driessel, S. J.
Foley, M. E.
Frankow, R. O.
Grundahl, A. T.
Heidner, A. H.
Kauth, P. M.
Koehler, J. P.
Nielsen, W. A.

Westby:
Strand, C. M.

West DePere:
Lenz, R. B.

Westfield:
Fredrick, H. Y.

West Salem:
Goedecke, R. H.
Wakefield, G. F.

Weyauwega:
Weller, E. A.

Whitehall:
MacCornack, R. L.
Simons, N. S.
Simonson, S. W.
Tyvand, J. C.

Whitewater:
Ambrose, S. H.
Miller, R. H.
Zahl, W. H.

Wild Rose:
Hadden, S. L.
Hong, Roy
Shemanski, L. S.

Williams Bay:
Wiswell, C. Y.

Winnebago:
Bellis, G. L.
Braun, R. F.
Hughes, B. J.
Mulvaney, J. J.
Perssion, L. B.
Petersik, J. T.

Winneconne:
Kilkenny, T. E.

Winter:
Smith, H. A.

Wisconsin Dells:
Broderick, C. F.
Gissal, F. W.
Houghton, J. H.
Sandeno, M. T.

Wisconsin Rapids:
Barnet, E. G.
Debus, E. E.
Garrison, R. E.
Glenn, E. C.
Handy, G. H.
Looze, J. J.
Nelson, W. L.
Pomainville, F. X.
Pomainville, L. C.
Smullen, J. J.
Waters, Donald

Withee:
Johnson, J. W.

Wittenberg:
Bland, P. T.
McCandless, E. E.
Olson, M. H.

Wonewoc:
Talbot, J. R.

Wood:
Bayley, H. G.
Beno, T. J.
Brandt, E. F.
Burns, T. A.
Calvy, T. L.
Carnesale, P. L.
Chase, Jules
Cunningham, R. T.
Dangle, H. C.
Dessel, B. H.
Finn, C. J.
Fox, G. E.
Grant, L. C., Jr.
Holm, A. G.
Kanin, H. J.
Kozalka, M. F.
Krygier, A. J.
Landis, F. B.
Leifert, W. C.
Lubitz, J. M.
Macht, A. J.
Mayer, R. J.
Meyer, J. M.
Monroe, M. W.
Murphy, G. V.
O'Connell, J. R.
Ogilvie, O. E.
Pfeffer, T. J.
Smith, M. B.
Teigland, J. D.
Thurwachter, L. F., Jr.
Trangsrud, H. A.
Welsh, E. C
Woods, E. W.
Yordy, F. S.
Zintek, S. S.

Wrightstown:
Vande Loo, F. B.

Wyocena:
de Neveu, A. V.

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Duffy, H. R. — Bremerton, Washington
East, John — Duarte, California
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Evans, F. L. — St. Louis, Missouri
Farrell, J. J. — Delmar, New York
Finseth, Landers — Marshallton, Delaware
Gadzikowski, Isabelle T. — Hopemont, West Virginia
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Gautsch, J. A. — Cody, Wyoming
Gay, L. A. — Columbia, Missouri
Grotts, B. F. — Champaign, Illinois
Gulbrandsen, Halbert — Fort Lyon, Colorado
Hackbarth, D. E. — New York, New York
Halfen, D. P. — Denver, Colorado
Hardin, C. A. — Kansas City, Kansas
Harris, N. M. — Portland, Oregon
Haseltine, C. P. — New York, New York
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Lynch, J. D. — Fort Benjamin Harrison, Indiana
Macaulay, W. L. — Moorhead, Minnesota
Manson, A. A. — Springfield, Illinois
Marshall Helen S. — Seattle, Washington
Matt, J. R. — Parkersburg, West Virginia
Mazzitello, W. F. — St. Paul, Minnesota
McCoy, J. T. — Arkansas, Texas
McLaughlin, B. C. — Philadelphia, Pennsylvania
Megna, Salvatore — Tucson, Arizona
Meyer, B. J. — Rochester, Minnesota
Moriarty, L. J. — Altadena, California
Morris, L. E. — Iowa City, Iowa
Mudge, W. A., Jr. — Elmhurst, Illinois
Nathan, Alvin — Cincinnati, Ohio
Nissenbaum, James — Philadelphia, Pennsylvania
O'Donnell, Mae J. — Muskogee, Oklahoma
O'Toole, J. J. — Harvard, Illinois
Prichard, M. C. — Long Beach, California
Reinsch, P. J. — Sacramento, California
Reist, P. Z. — Girard, Ohio
Retter, R. H. — Rochester, Minnesota
Rogers, R. J. — Rochester, Minnesota
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Seegar, S. J. — Dallas, Texas
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Shimpa, J. F. — Cheyenne, Wyoming

Shonyo, E. S. — Rochester, Minnesota
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Thorngate, George III — Shanghai, China
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Warrick, J. D. — Camarillo, California
Waters, R. M. — Orlando, Florida
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Wells, May R. — Belleville, Illinois
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Pusey, W. A. — Chicago, Illinois
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Bartran, W. H. — Green Bay
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Beebe, S. D. — Sparta
Belitz, A. E. — Pepin
Bolton, E. L. — Appleton
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Gavin, S. E. — Fond du Lac
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Grosskopf, E. C. — Milwaukee
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Hardgrove, J. H. — Eden
Harper, C. A. — Madison
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Haushalter, H. P. — Milwaukee
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Hipke, William — Marshfield
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Jackson, J. A. — Mosinee
Junck, J. A. — Sheboygan
Kelly, W. W. — Green Bay
Lemmer, G. N. — Madison
Leonard, C. W. — Fond du Lac
Linn, W. N. — Oshkosh
Lockhart, C. W. — Mellen
Lockhart, J. W. — Oshkosh
Looze, J. J. — Wisconsin Rapids
Ludden, H. D. — Mineral Point
Lumsden, William — Menomonie
Lundmark, L. M. — Ladysmith
Maes, C. G. — Kimberly
Malloy, T. E. — Random Lake
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Notbohm, W. R. — Dousman
Nuzum, T. W. — Janesville
Olmsted, A. O. — Green Bay
Panetti, P. A. — Hustisford
Peehn, F. G. — Sturtevant
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Radloff, A. C. — Plymouth
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Schroeder, H. F. — Marinette
Smith, J. F. — Wausau
Smith, S. M. B. — Wausau
Tasche, C. T. — Sheboygan
Thomas, W. O. — Clinton
Tibbitts, U. J. — Waukesha
Twohig, D. J. — Fond du Lac
Van Altena, L. A. — Cedar Grove
Webb, E. P. — Beaver Dam
Wheeler, W. P. — Oshkosh
Wilkinson, M. R. — Oconomowoc
Williamson, G. H. — Neenah
Witcpalek, W. W. — Algoma
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Statement of the American Medical Association Concerning Membership and Fellowship

THE House of Delegates of the American Medical Association at its meeting in Washington, D. C., December 6 to 8, 1949, adopted amendments to the By-Laws of the American Medical Association whereby Division One, Chapter II, Tenure of Membership, has been changed to read as follows:

Chapter II.—Tenure and Obligations of Membership; Dues

Section 1.—When the Secretary is officially informed that a member is not in good standing in his component society he shall remove the name of said member from the membership roll. A member shall hold his membership through the constituent association in the jurisdiction of which he practices. Should he remove his practice to another jurisdiction, he shall apply for membership through the constituent association in the jurisdiction to which he has moved his practice. Unless he has transferred his membership within six months after such change of practice, the Secretary shall remove his name from the roster of members.

Sec. 2.—Annual dues, not to exceed $25.00, may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to his constituent association for transmittal to the Secretary of the American Medical Association.

An active member who is delinquent in the payment of such dues for one year shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address.

Any former member who has forfeited his membership because of being delinquent in payment of dues may be re-instated on payment of his indebtedness.

You will note that the following important changes have been made:

(A) The word "Dues" has been added to the title of Chapter II.

(B) Chapter II has been divided into two sections.

(C) The first sentence of Chapter II, which read, "Membership in this Association shall continue as long as a physician is a member of a component society of the constituent association through which he holds membership," has been deleted.

(D) The words "of the American Medical Association" have been added after the word "Secretary" where clarification is necessary.

(E) The sentence, "An active member shall pay dues or assessments as may be prescribed by the Constitution or By-Laws," has been deleted.

(F) The words "in the American Medical Association" have been added after the words "shall forfeit his active membership" in the second paragraph of Section 2.

(G) The sentence forming the third paragraph of Section 2, with regard to reinstatement, is a new addition to Chapter II.

(H) A new paragraph, forming the first paragraph of Section 2, providing for annual dues not to exceed $25.00 has been added to Chapter II.

The House of Delegates, on Recommendation on the Board of Trustees, set the Membership Dues for the Year 1950 at $25.00.

The full effect of the new provisions will have to be studied and developed during the next year. However, the following interpretations of the amended By-Laws are offered for your guidance at this time:

(a) Active membership in the American Medical Association will continue to be limited to those members of constituent associations who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) are entitled to exercise the rights of active membership in their constituent associations as provided in Article 5 of the Constitution of the American Medical Association.

(b) A member of the American Medical Association shall lose his membership in the Association when the Secretary of the American Medical Association is officially informed that a member is not in good standing in his component society *or is delinquent in the payment of the American Medical Association dues established by the above change in the By-Laws.*

(c) Forfeiture of membership in the American Medical Association due to failure to pay dues will have no effect on membership in the component or constituent medical societies unless the component or constituent societies amend their respective constitutions and by-laws. It is, therefore, possible that a physician may be a member of his component and constituent societies and at the same time not be a member of the American Medical Association.

(d) The amended By-Laws provide for the collection of the American Medical Association membership dues by the constituent associations for transmittal to the Secretary of the American Medical Association. The detailed method to be adopted by each constituent association will vary in each state. In general, the method utilized by each state for the collection of its own component and constituent association dues should be followed.

Some of the problems involved in the collection and transmittal of dues will be considered in a later communication to you.

It is planned to provide each member of the American Medical Association a membership card and certificate of membership when his dues are paid.

It will be necessary for the Secretary of the American Medical Association to notify those members who are delinquent in the payment of their dues, and this office will, therefore, require a complete list of all active dues paying members.

No changes have been made in the Constitution and By-Laws of the American Medical Association with respect to Fellowship. Eligibility for Fellowship and annual Fellowship dues of $12.00 remain the same. Under the present By-Laws a Fellow will pay for the year 1950 total membership and Fellowship dues of $37.00.

The following members may be exempted from the payment of the $25.00 American Medical Association membership dues: Retired members; members who are physically disabled; interns, and those members for whom the payment of such dues would constitute a financial hardship.

No member should be exempted from the payment of his American Medical Association dues who is not exempted from his component and constituent society dues.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY REPEATS RESIDENCY TRAINING REQUIREMENTS

The American Board of Obstetrics and Gynecology has not made, nor is it contemplating, any changes in its residency training requirements, despite rumors of an increase in training years. Eligibility requirements remain the same, namely, three years of acceptable formal training, followed by at least two years of post-training practice in the specialty.

Hospitals are inspected and approved for training jointly by the Council on Medical Education and Hospitals of the American Medical Association and this Board. Approvals are granted for training periods of one, two, and three years, depending on the available facilities and the findings of the survey inspections.

This Board has no objection to residency services being arranged by hospitals for periods longer than three years, unless this dilutes the candidate's clinical training opportunities too much during the first three years. However, the Board does not accept a fourth year, or more, of residency training as a substitute for any part of the required two years of post-training practice.

The importance of post-training practice in the specialty is emphasized as an opportunity for maturing of the candidate and for colleague appraisal of a man's ability when working on his own responsibility in his chosen community. The only exception to this ruling is in the case of men advancing from their training into full time teaching positions. These men then must complete at least two years in such positions.

Copies of the bulletin of this Board, outlining the above requirements in more detail, are available to hospital administrators or to candidates, upon application. Inquiries should be directed to Paul Titus, M. D., Secretary, American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

Principles of Medical Ethics of the American Medical Association

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803).

CHAPTER 1

GENERAL PRINCIPLES

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATION INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patients on or the sale of surgical instruments, appliances and medicines, nor

* Sir Thomas Watson.

profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

DUTIES OF PHYSICIANS TO THEIR PATIENTS

STANDARDS, USEFULNESS, NONSECTARIANISM

SEC. 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLDING THE HONOR OF THE PROFESSION

SEC. 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be consid-

* Nicon, father of Galen.

ered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

Article II.—Professional Services of Physicians to Each Other

DEPENDENCE OF PHYSICIANS ON EACH OTHER

Sec. 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

Sec. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

Sec. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

Article III.—Duties of Physicians in Consultations

CONSULTATIONS SHOULD BE ENCOURAGED

Sec. 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

Sec. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

Sec. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

Sec. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATIONS

Sec. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

Sec. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultant; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

Sec. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the

differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV. —DUTIES OF PHYSICIANS IN CASE OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SEC. 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENTS OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

ARBITRATION

SEC. 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SEC. 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

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CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or violation, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

PHYSICIANS AS CITIZENS

SEC. 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable disease. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

BOARD OF OPHTHALMOLOGY ANNOUNCES 1950 EXAMINATION DATES

Practical examinations for acceptable candidates in the American Board of Ophthalmology will be held in Boston, May 22–26; and in Chicago, October 2–6. An examination will be given on the West Coast in January 1951.

Applications are now being accepted for the 1951 written test of the Board, by means of which candidates for certification are accepted for examination. Applications will be considered in order of receipt until the quota is filled.

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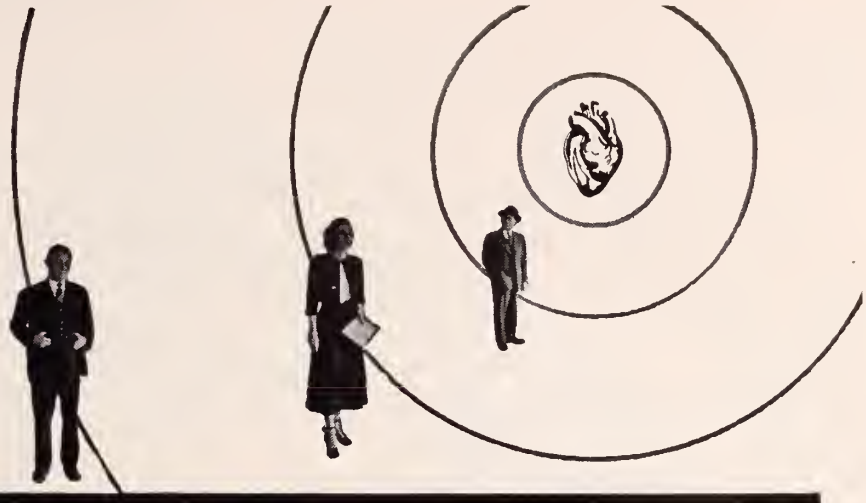

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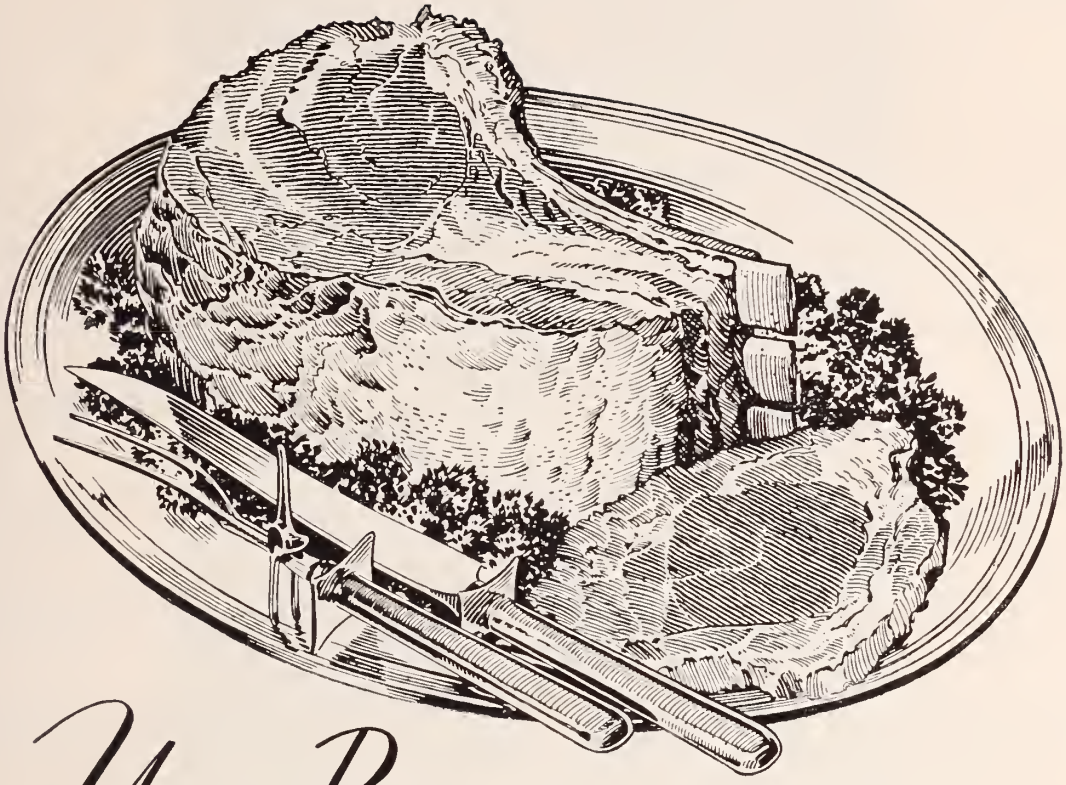

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

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YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes; Annual Narcotics Registration.

1. File your Wisconsin and federal income tax returns as early in 1950 as possible, *but not later than March 15.*
2. File a Social Security form quarterly just as in past years. Not later than January 31, 1950, you must file the return for the quarter ending December 31, 1949, and pay the employment tax due for that quarter.
3. The withholding tax, or tax withheld from the income of your subject employes, is due January 31 to cover the last quarter of 1949. Formerly Social Security and withholding taxes were separately returned and separately payable each quarter. They are now returnable together each quarter. Thus, the first return will be due on April 30 for the first quarter of 1950, on July 31 for the second quarter, and on October 31 for the third quarter. On January 31, 1951, you must file a list of employees and amounts paid to them in salaries; also the amounts withheld during 1950. See also item 6 of this section on "Taxes."
4. The first quarterly estimate of your own income for 1950 is due on March 15. Further estimates are due on June 15, September 15, and January 15. On those dates you may also amend your March estimate, if there has been a substantial change in your income.
5. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1950. You are subject to penalties for overlooking either the registration or the tax.
6. Any month in which the withholding tax of your employees exceeds $100, you must deposit such amount in a bank designated for your area, instead of waiting until the end of the quarter and at that time remitting to the United States Treasury.

Annual Registration:

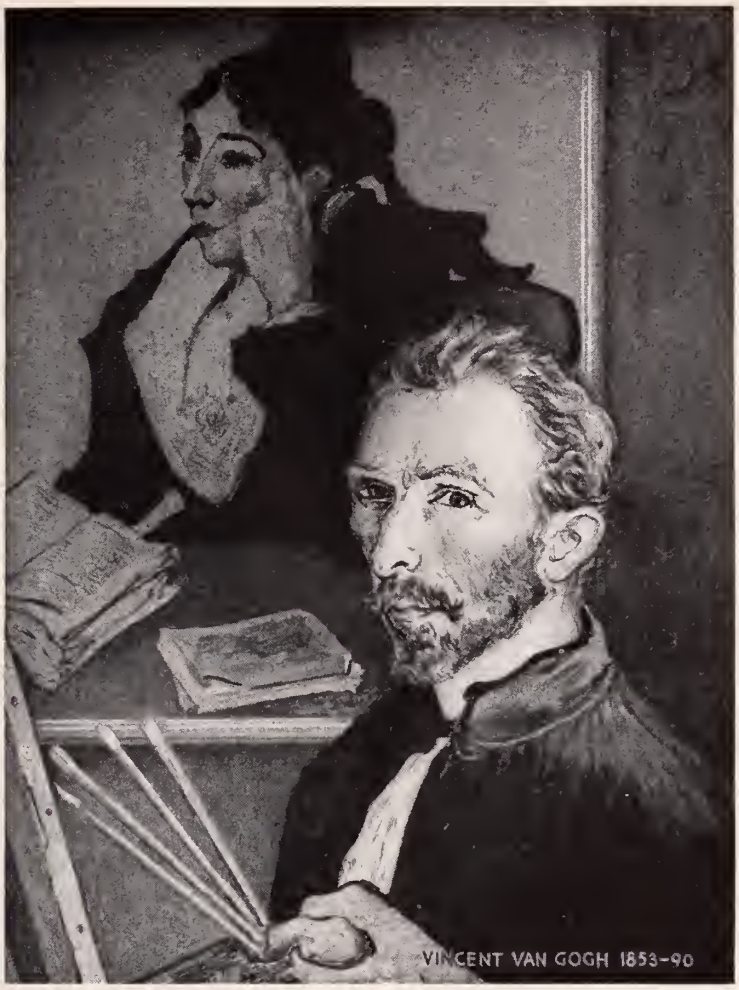
1. Register with the Secretary of the Wisconsin State Board of Medical Examiners in the month of January, 1950. This registration will be on a form furnished by the Board of Medical Examiners.

Change of Residence:

1. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
2. If you take up residence in another county, record your license with the county clerk so that no question will arise as in the collection of your fees, or your right to give testimony in a legal proceeding.
3. If you have changed the address or place of residence or professional office or should open an additional office after your annual registration in January, 1950, you must, within 30 days thereafter, notify the Board of Medical Examiners in writing of such change.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others as described in the article on page 27.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, epileptic, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the insane. Sec. 51.01 (6), statutes.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.
5. Report immediately to the local health officer in writing the name, age, and address of every person diagnosed as afflicted with "epilepsy or similar disorder characterized by lapses of consciousness". Sec. 141.08, statutes.
6. Report *immediately* the following deaths, as required by Section 366.20, statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate.



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No. 53, A, 1943.

A JOINT RESOLUTION

Urging physicians and dentists to maintain records of services rendered to veterans of the present war.

WHEREAS, It is essential to the recovery of federal war compensation by veterans of the present war that a given disability be shown to have resulted from and in connection with the military service of the claimant, and

WHEREAS, It is also essential to proof of such service-connected disability that all treatment records kept by a physician or dentist of the claimant be available to military and federal authorities, and the absence of such a record may defeat the bona fide claim of a veteran; now, therefore, be it

Resolved by the assembly, the senate concurring, That the state board of health, state board of medical examiners, the state board of dental examiners, and the several professional societies be requested forthwith to ask that all practicing physicians and dentists ascertain, so far as possible, whether patients are now or are on any subsequent date veterans of the present war, and that in the case of each such veteran his case history be preserved for at least 6 years after the date the last professional service is rendered by such physician or dentist. Be it further

Resolved, That each of the above boards and professional societies be further requested to contact all of their respective licensees and members at least once a year for the balance of the war, and at least once each year for the first 6 years following the war, so as to remind all such persons of the importance to the war veterans of preserving such professional records; and be it further

Resolved, That duly attested copies of this resolution be transmitted forthwith to such boards and professional organizations.

Conrad Shearer — PRESIDENT PRO TEMPORE OF THE SENATE.

Vernon W. Thomson — SPEAKER OF THE ASSEMBLY.

Lawrence R. Larsen — CHIEF CLERK OF THE SENATE.

Arthur L. May — CHIEF CLERK OF THE ASSEMBLY.

This resolution was introduced by Assemblyman Lyall T. Beggs, of Dane County, a veteran of the first World War and Past Vice-Commander of the American Legion. It will be printed periodically in *The Wisconsin Medical Journal* during the next several years.

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D. Cooper Ayres, Green Bay 1857
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E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862
(No meetings held from 1863 through 1866; apparently no new officers).
Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favil, Madison 1872
Harmon Van Dusen, Mineral Point 1873
M. Waterhouse, Portage 1874
J. T. Reeve, Appleton 1875
J. B. Whiting, Janesville 1876
J. K. Bartlett, Milwaukee 1877
Darius Mason, Prairie du Chien 1878
Nicholas Senn, Milwaukee 1879
J. G. Meachem, Sr., Racine 1880
Ira Manley, Jr., Markesan 1881
William Meacher, Portage 1882
T. P. Russell, Oshkosh 1883
N. M. Dodson, Berlin 1884
E. W. Bartlett, Milwaukee 1885
G. M. Steele, Oshkosh 1886
S. C. Johnson, Hudson 1887
L. G. Armstrong, Boscobel 1888
J. R. Barnett, Neenah 1889
E. M. Rogers, Hartford 1890
G. D. Ladd, Milwaukee 1891
G. F. Witter, Grand Rapids, Mich. 1892
B. T. Phillips, Menominee, Mich. 1893
B. C. Brett, Green Bay 1894
Almon Clarke, Sheboygan 1895
F. W. Epley, New Richmond 1896
B. O. Reynolds, Lake Geneva 1897
William Mackie, Milwaukee 1898
Herman Reineking, Milwaukee 1899
W. T. Sarles, Sparta 1900
J. F. Pritchard, Manitowoc 1901
W. H. Neilson, Milwaukee 1902
J. V. R. Lyman, Eau Claire 1903
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C. W. Oviatt, Oshkosh 1905
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D. J. Hayes, Milwaukee 1919
C. R. Bardeen, Madison 1920
H. W. Abraham, Appleton* 1921
M. A. McGarty, La Crosse 1921
S. Hall, Ripon 1922
F. G. Connell, Oshkosh 1923
Rock Sleyster, Wauwatosa 1924
Wilson Cunningham, Platteville 1925
Joseph F. Smith, Wausau 1926
Arthur W. Rogers, Oconomowoc 1927
John J. McGovern, Milwaukee 1928
Karl W. Doege, Marshfield 1929
F. J. Gaenslen, Milwaukee 1930
A. J. McDowell, Soldiers Grove** 1931
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Otho Fiedler, Sheboygan 1932
Reginald H. Jackson, Madison 1933
Stanley J. Seeger, Texarkana, Texas 1934
T. J. O'Leary, Superior 1935
R. M. Carter, Green Bay 1936
Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
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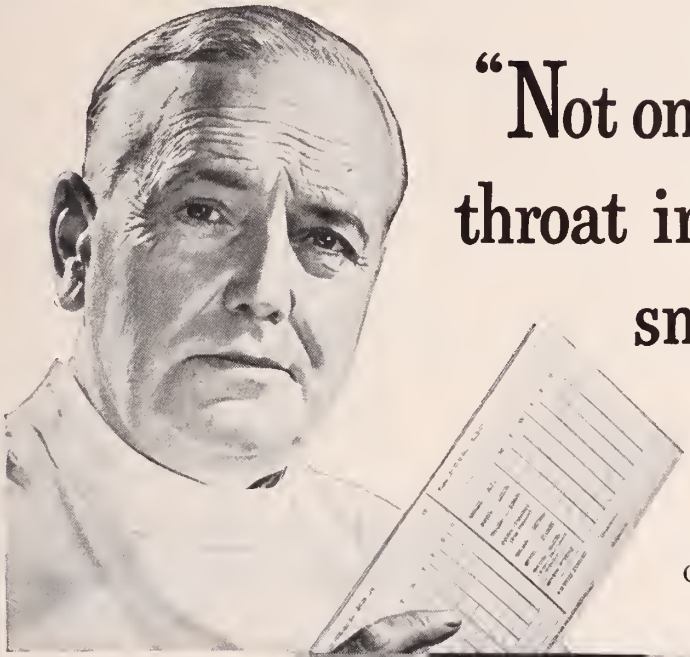
R. P. Sproule, Milwaukee 1941
Gunnar Gundersen, La Crosse 1942
F. E. Butler, Menomonie 1943
R. M. Kurten, Racine 1944
Charles Fidler, Milwaukee 1945
P. R. Minahan, Green Bay 1946
C. A. Dawson, River Falls 1947
W. D. Stovall, Madison 1948
K. H. Doege, Marshfield 1949

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.

Throat Specialists report on 30-day test of Camel smokers:



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Dr. Louis M. Jermain†	1931
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Dr. Olin West	1934
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Dr. Arthur J. Patek	1935
Dr. Joseph F. Smith	1937
Dr. Eben J. Carey†	1938
Dr. William S. Middleton	1938
Dr. Fred G. Johnson†	1939
Dr. William D. Stovall	1940
Dr. Ludvig Hektoen***	1941
Dr. Stephen E. Gavin	1944
Dr. F. Gregory Connell	1947
Dr. E. R. Schmidt	1949

** Then president of the University of Wisconsin and professor of zoology.
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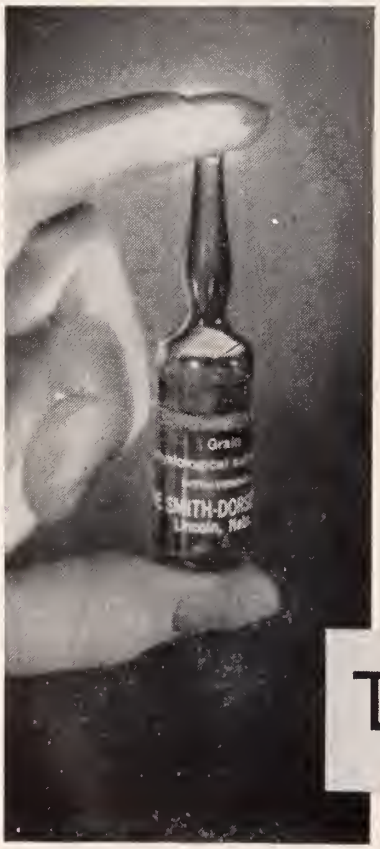

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Marinette, Marinette General Hospital
Milwaukee, Milwaukee County General Hospital (2); South View Hospital (4)
Neenah, Theda Clark Memorial Hospital (2)
Oshkosh, Mercy Hospital
Port Washington, St. Alphonsus Hospital
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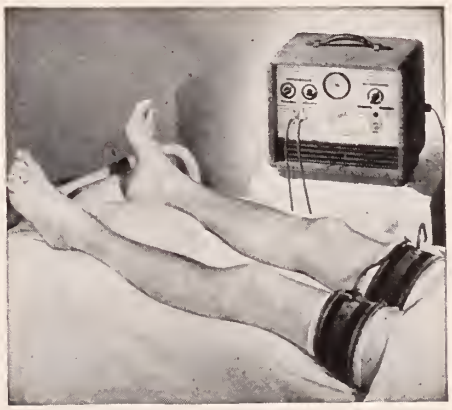

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Clinical Biochemistry. By Abraham Cantarow, M. D., Professor of Biochemistry, Jefferson Medical College; and Max Trumper, Ph. D., Commander, H (S), USNR., Lecturer in Clinical Biochemistry and Basic Science Coordinator, Naval Medical School National Naval Medical Center, Bethesda, Maryland. Fourth edition. Pp. 642, with 38 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $8.00.

This book is an effort to correlate information concerning the chemical composition of the body, particularly that information obtainable by the usual clinical laboratory procedures, with disturbances in normal function. The emphasis of the clinical laboratory, and therefore of this volume, is on static, or "anatomical" chemistry, as opposed to dynamic, or "physiological" chemistry. The analysis of a given sample of blood or urine may produce results as informative as the demonstration of an enlarged thyroid, or as sterile as the fact that a certain individual weighs 70 kg., without any knowledge as to his previous weight. As stated in the preface, "purely abstract and theoretical considerations have been excluded." In one of the few attempts to ground observation in theory, Soskin's analogy of blood sugar maintenance to a furnace system given on page 12, the result is confusion rather than clarification.

It is unfortunate the authors have not seen fit to modify their approach in this edition. If a real understanding of biochemistry of disease is ever to be attained, it can only come through a synthesis of the knowledge of the clinician and a fundamental comprehension of the complex active interplay of the organism's metabolic reactions.

Some curious inconsistencies in emphasis are apparent. Thus calcium metabolism occupies twenty pages, and iodine nearly seven, while phosphorus and iron are dismissed in four and one-half each, and sulfur in two and a half.

From a reading of the introductory section on acid-base balance, the uninformed might gather, since the text has not been changed from the 1932 edition, that the hydrogen ion is practically a postwar discovery. The emphasis on elementary detail in this section is in contrast to most of the book, where a fair preliminary knowledge is evidently presumed.

As it is, this volume will represent a valuable reference work for the informed clinician. The uninitiated, gifted with an excellent memory for empirical detail, may also gain useful working knowledge, but it is of little interest to the student of biochemical theory. R. W. M.

A Textbook of Neuropathology; with Clinical, Anatomical and Technical Supplements. By Ben W. Lichtenstein, B. S., M. S., M. D., Associate Professor of Neurology, the University of Illinois College of Medicine; State Neuropathologist, Illinois Neuropsychiatric Institute. Pp. 474 with 282 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price 9.50.

This book is by far the best of recent textbooks on neuropathology. The author, of course, does not intend that his book replace the older and more complete works. He does, however, present the basic neuropathologic information in a concise and easily assimilable manner.

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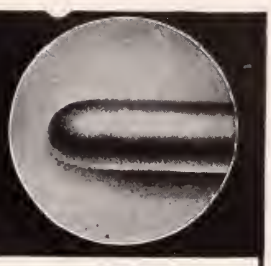

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The first two chapters deal with nomenclature and methodology, while the third discusses pathogenesis of central nervous system disease. Then follow chapters on degeneration, regeneration, and vascular diseases. Chapters are then devoted to hydrops, hyperplasia, neoplasms, malformations, deformities and metabolic diseases. A full chapter is devoted to muscular diseases. The chapters on neurologic syndromes will be useful. Finally, a neuroanatomic supplement and a chapter on staining technic have been appended. The material is exceptionally well organized and disease processes are described fully without exhaustive argumentation. The author's outlook is balanced and his meanings lucid. The book is profusely illustrated with many gross and microscopic photographs which convey information inherent in the written word.

The book is primarily of interest to pathologists and those engaged in the neurologic sciences. Students will find the book readable and instructive. Internists and those interested in general medical practice will find descriptions of the effects of disease elsewhere on the central nervous system. It is highly recommended for anyone desiring a brief, clear description of disease processes in the brain and spinal cord. H. F. S.

Psychiatry in General Practice. By Melvin W. Thorner, M. D., D. Sc., Assistant Professor of Neurology, The Graduate School of Medicine, University of Pennsylvania. Pp. 659. Philadelphia and London, W. B. Saunders Company, 1948. Price $8.00.

"Psychiatry in General Practice" successfully fulfills the need for a text which accurately presents the subject of basic psychiatry as an integral part of the everyday practice of medicine.

This difficult task has been accomplished by the author by a rather unique approach. The various syndromes and reaction types have not been identified by and referred to in the usual terms. Instead one of four sections is devoted totally to types of people, e.g., anxious people, unhappy people, dreamy people, confused people, etc. The type of persons is elaborated through excellent case histories taken from clinical practice. These are augmented by explanatory marginal notes and followed by didactic and practical discussion. The effect is to convey a workable concept of the patient's problem as it occurs in his social and interpersonal environment.

The section on methods deals with technic of diagnosis and essentials of therapy in such a way as to make them more meaningful as well as to delineate their limitations.

In the appendix are a classification of mental disorders and a résumé of commitment procedures which should be most helpful and a source of quick reference for the busy physician. The bibliography is excellent. This book is remarkable for its clarity and avoidance of technical language. The readers should feel rewarded by a more integrated concept of behavioral maladjustment as it is seen in general practice and this understanding should make for better relationships with those patients whose clinical problems have a large emotional component. E. M. B.

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AVAILABLE: Physician aged 28, married, graduate of University of Wisconsin, who just completed two years in the Army, desires assistantship with surgeon or with general practitioner who does his own surgery, or association or group practice opportunity in Wisconsin. Address replies to No. 278 in care of Journal.

PHYSICIAN WANTED: Having recently purchased the Grant Community Hospital in Lancaster, I need an associate in general practice. Preferably someone with surgical training. Opening available January 1, 1950. H. W. Carey, M. D., Lancaster, Wisconsin.

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The
MEDICAL FORUM

The Wisconsin Medical Journal January, 1950

MENTAL HYGIENE COMMITTEE PLANS HOSPITAL SURVEY; URGES PROPER CARE OF SEX OFFENDERS

Doctor Posters Being Produced in Milwaukee

Madison, January 3—The posters depicting the famous painting of Sir Luke Fildes, "The Doctor," are being produced for the entire nation by Klau-Van Pieterson-Dunlap Associates, an advertising and merchandising concern located in Milwaukee.

Thousands Distributed

Hundreds of thousands of these posters are being distributed to persons interested in the national education campaign of the American Medical Association. Frank V. Birch, executive vice president of the concern, reports that his company originated the idea which was adopted by Whitaker and Baxter in its campaign against compulsory health insurance. The concern has done a considerable amount of creative work for the American Medical Association.

Wisconsin Gets Aid for Water Pollution Control

Washington, D. C., Nov. 30—Wisconsin's water pollution control program received a booster shot of Federal aid from the Public Health Service with the announcement that $16,808 has been appropriated to the state to help combat conditions which are threatening the quality of the state's water resources.

State Gets $16,808

Wisconsin received this money as a share of nearly $1,000,000 granted to state and interstate agencies for studies of water pollution resulting from industrial wastes.

The Wisconsin State Board of Health received $9,608 for studies related to uniform standards of industrial waste and sewage treatment works.

DR. CHRISTOFFERSON

HYGEIA'S NEW NAME IS "TODAY'S HEALTH"

Chicago, Dec. 23—The name of Hygeia, health magazine of the American Medical Association, will be changed effective with the March, 1950, issue. The magazine's new name will be "Today's Health."

The masthead of the January number of Hygeia also carries for the first time the name of Dr. W. W. Bauer, former city health officer of Racine, as editor, succeeding Dr. Morris Fishbein.

Hygeia was established by the American Medical Association in 1923. Written for the layman, it has become one of the most widely quoted health education periodicals in the United States. There will be no change in fundamental policy under the new editorship or under the new name.

ON THE INSIDE

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Madison, Jan. 12—Sex offenders should be sent to the state prison at Waupun, or to special institutions not yet provided, instead of mental hospitals where they endanger other patients, the State Medical Society's committee on mental hygiene and institutional care reported after a meeting in Oshkosh on Jan. 8.

Members of the committee are Dr. H. H. Christofferson, Colby, chairman, and Drs. B. J. Hughes, Oshkosh; P. R. Minahan, Green Bay; W. A. Munn, Janesville, and E. D. Schwade, Milwaukee.

Endanger Mental Patients

Because the courts have interpreted sex offenses as a sign of mental illness, sexual psychopaths are being committed to Mendota and Winnebago hospitals, Dr. Christofferson stated. The director of the Winnebago institution, Dr. Hughes, argues that persons suffering from homosexuality have no place in a mental hospital because the impaired mentality of other patients makes them "easy prey for further irregularities."

The committee recommends that criminal sexual psychopaths be properly housed at Waupun until such time as a special institution for the treatment of sex offenders is provided by the state.

Will Survey Hospitals

The committee also plans to survey all general hospitals to find out how they can best provide special facilities for mental patients awaiting transfer to Winnebago or Mendota.

Some mental patients, the committee says, are being sent fro general hospitals to institutio without receiving much need medical or surgical treatme merely because the hospitals are prepared to house persons who rupt hospital quiet and req special attention.

Hospital Construction Approved for Wisconsin

Hospital	City	County	Type	Beds
(Construction approved Feb. 1948)				
Holy Family	New Richmond	St. Croix	Gen.	32
Wm. Finney Mem.	Clintonville	Waupaca	Gen.	50
Memorial Hosp.	Ft. Atkinson	Jefferson	Gen.	62
Kempster Hall	Winnebago	Winnebago	Ment.	240
Municipal Hosp.	Platteville	Grant	Gen.	30
(Construction approved July 1948)				
Vernon Memorial	Viroqua	Vernon	Gen.	25
Madison General	Madison	Dane	Chr.	100
Memorial Hosp.	Tomah	Monroe	Gen.	25
Memorial Hosp.	Menomonie	Dunn	Gen.	32
St. Joseph's	Dodgeville	Iowa	Gen.	30
Ladd Memorial	Osceola	Polk	Gen.	10
Memorial Hosp.	Burlington	Racine	Gen.	25
Memorial Hosp.	Algoma	Kewaunee	Gen.	30
St. Benedict	Durand	Pepin	Gen.	41
Marinette Gen.	Marinette	Marinette	Gen.	45
St. Joseph's	Rice Lake	Barron	Gen.	41
Luther Hosp.	Eau Claire	Eau Claire	Chr.	61
(Construction approved Sept. 1949)				
Memorial Hosp.	Darlington	Lafayette	Gen.	35
Municipal Hosp.	Ripon	Fond du Lac	Gen.	13
Memorial Hosp.	Waukesha	Waukesha	Gen.	60
Langlade Co. Mem.	Antigo	Langlade	Gen.	25
Lutheran Hosp.	Oconomowoc	Waukesha	Gen.	25
Lutheran Hosp.	La Crosse	La Crosse	Chr.	50
State Laboratory of Hygiene	Madison	Dane	Lab.	------
(Construction approved Jan. 1950)				
Lakeland Hosp.	Woodruff	Oneida	Gen.	15
Community Hosp.	Spooner	Washburn	Gen.	15
St. Luke's Hosp.	Milwaukee	Milwaukee	Gen.	180
St. Francis Hosp.	Milwaukee	Milwaukee	Gen.	390
Victory Memorial	Stanley	Chippewa	Gen.	12
Memorial Hosp.	Berlin	Green Lake	Gen.	20
Memorial Hosp.	Sheboygan	Sheboygan	Chr. &	48
			Psych.	19
Columbia Hosp.	Milwaukee	Milwaukee	Psych.	22
St. Anthony's	Milwaukee	Milwaukee	Chr.	32
Mt. Sinai	Milwaukee	Milwaukee	Chr. &	50
			Psych.	16
Evang. Deaconess	Milwaukee	Milwaukee	Chr. &	25
			Psych.	35

The above construction has been approved by the State Board of Health. Most of those hospitals now under construction were financed on the basis of one-third federal funds and two-thirds local funds. Those approved in Jan. 1950 may receive as high as 45% federal funds.

35 Hospital Projects Get Federal Funds

Madison, Jan. 10.—The state board of health reports that nearly $6,000,000 in federal aid has been approved for 35 hospital construction projects in Wisconsin, since the federal hospital survey and construction act (Hill–Burton bill) became effective in 1947.

Local communities provided another $6,000,000 to meet their share of construction costs. A large majority of the new hospital beds created by this program will increase facilities serving rural areas.

Ten projects of the 35 are now under construction. One, the Holy Family hospital at New Richmond, is in full operation. Fourteen others will be started in 1950.

"GP" Journal Starts Publication in March

Kansas City, Dec. 23—The first issue of "GP—Published by the American Academy of General Practice," is scheduled for publication in March, 1950. The name "GP" was selected for the Journal because it was distinctive and thoroughly indicative of the content of the Journal, according to Mac F. Cahal, executive secretary of the Academy of General Practice.

Each issue will include four or five original articles written especially for "GP" by leading medical authorities. In addition, there will be medical editorials, a section on economics, a review of current literature, and a monthly therapeutic conference.

PRESS ARGUES SOCIETY'S STAND ON CARE OF AGED

Green Bay Paper Answers Wisconsin Citizens Public Expenditure Survey

Wisconsin Tax News
Nov. 29, 1949

"PUBLIC DEMAND"

The pressure already being built up for more welfare aids in the next legislative session, still more than a year away, indicates how so-called "public demand" is stimulated.

This time it's the State Medical Society, which while it fights socialized medicine, is developing, according to press reports of its recent convention, a program aimed at stimulating greater public expenditures for welfare purposes.

Called for is a campaign in behalf of a "more adequate" program for the care of aged and infirm, a suggestion for the establishment of county infirmaries for the aged even though state aid for such a program failed to receive approval in the last legislative session, and other higher welfare expenditures. In one instance support for federal funds was indicated "provided there is no dictation of policy."

Entirely aside from the merits or demerits of the medical society proposals, the instance vividly indicates how "public demand" is built up. In this case a special interest group frankly reveals its intention to develop a campaign for higher welfare expenditures, so as to enlist public support.

It will be interesting to watch the development of this campaign, which will serve as a particularly good example of the fact that "public demand" actually is not a case of spontaneous desire for a specific thing on the part of the public, but rather a carefully planned and executed promotion program by a special minority group.

NEED A SPEAKER?

If you want to provide a speaker for any group meeting on compulsory health insurance and medical problems, call on the State Medical Society's Speakers Bureau. More than 75 speakers available for all areas of the state. Please notify early.

Green Bay Press–Gazette
Dec. 13, 1949

Wisconsin Doctors and Welfare Laws

The Wisconsin Citizens Public Expenditures Survey makes a point worthy of consideration when it argues that much of the ostensible public pressure for new spending in government is inspired by politically subtle leaders of pressure blocs, but it selects a poor example to support its thesis.

It complains in a recent edition of its house organ about the suggestions from the Wisconsin State Medical Society for better public services to meet the custodial problems of the aged and the infirm. The Survey, which is an organization of taxpayers which has done a great deal of good work in analyzing our Wisconsin public affairs, frowns upon that as an example of false stimulation of welfare spending pressure.

Doubtless the Survey's understanding of the mechanics of current pressure politics is good, but we doubt that its grumbling about the medical society's attitude is either fair or accurate in this case. Our practicing physicians know better than anyone else in Wisconsin the acute and growing problems of caring for our indigent oldsters and our chronically ill, and realize better than most citizens, perhaps, the implications of our population statistics that the community is growing older steadily. This problem of caring for the aged will become more troublesome in the future, and our doctors have been patiently telling us about it in the medical society's proceedings for the last half a dozen years.

The Survey intimates that there is something inconsistent about the society's vigorous battle against nationalization of medical services in the Congress, and its advocacy of broader local welfare services. But surely the logic of its position is evident. The society is merely implementing its conviction that the avoidance of federalization of all of our public services is best assured by exhibiting a willingness to attack them at home. If the state of Wisconsin can effectively meet the problem of taking care of the aged and the chronically ill, there will be less justification for turning to Washington for welfare legislation. To ignore the problem is useless. It is too evident to everyone.

And if, as the Survey seems to fear, the medical society's leadership in drawing public attention to this acknowledged problem results in "public demand" upon the next Wisconsin legislature for a welfare program directed toward the benefit of the aged, that only means that our doctors have the respect of their communities and that they can lead public opinion on public issues on which they are expert.

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THE HEALTH PROGRAM PRESIDENT TRUMAN WANTS

Doctor Bills Would Be Turned Into 3% Tax on Incomes Up to $3,600, But the Experts Can't Estimate What Ultimate Cost May Be

(Reprinted from U. S. News & World Report, an independent weekly magazine on national and international affairs, published at Washington. Copyright, 1949, United States News Publishing Corporation.)

Washington, D. C. — National health insurance on a compulsory basis is in an advanced planning stage within the administration. President Truman, in his January message to congress, is to recommend a plan that will cover the cost of medical care for most people. Even advocates of the plan do not expect immediate passage of the health insurance program. But congress will begin a study of the president's plan in 1950.

The health program will provide an issue of growing importance in the 1950 congressional campaign and again in the 1952 presidential campaign. Already questions about details of the plan are piling up in Washington.

The big questions being asked by laymen and doctors, by prospective patients and the men who would treat them, are: How would the plan work? What kinds of service would be given under the health program? Who would pay for it, and how much? What changes would the plan make in the relations between doctors and patients? What problems remain to be solved before the plan would go into effect? All these are questions that will be threshed out in the political debates that lie ahead.

How Truman Plan Would Work Out

If Mr. Truman's plan were adopted, here is how it would work:

John Jones is a bookkeeper making $3,600 a year. He is worried about doctor bills. His young son has headaches and is falling behind his class. The teacher says the youngster may need glasses. But another baby is due. This will cost money. And John Jones himself feels the need of a physical checkup. The Jones family needs from $75 to $200 worth of physical repairs now.

Under Mr. Truman's plan, John Jones would have his physical checkup and whatever treatment might be needed. Mrs. Jones would have doctor's care and be hospitalized for the birth of her child. The child would get pediatric treatment after birth. Young Johnny Jones would go to a specialist for an eye examination. Glasses would be provided if needed.

For all this, there would be no worry about expenses on the part of the Jones family. Members of the family simply would give their names, show a health insurance card, and the doctor would jot down its number. After the work was done, he would send the bill to a government agency.

Who Would Pay

So far as the Jones family was concerned the bill would have been paid by regular deductions from Mr. Jones' pay check. Since he earned $3,600 a year, his employer would deduct at a rate of $54 a year. This would be about $1.04 a week. To this, the employer would add another $1.04 a week, or $54 a year, from his own till and send the total in as a special tax. If John Jones earned less than $3,600, the payments would be smaller; if he earned more, they would be no larger.

If John Jones were self-employed, he would pay, perhaps, as much as $108 a year as an addition to his income tax. If he and his family were a public charge, the tax payments would be made for them by a charitable agency.

The amount paid to doctors and hospitals for the services would depend on the fees that might be fixed by local boards. These would vary from area to area. Doctors would serve on these boards and set the fees. But there would be public representation, also.

The majority of the doctors in a given locality would decide which of several ways of payment they preferred. They might be paid on the basis of a fee for each service. They might be paid a salary. They might be paid so much for each patient on their list. Or they might be paid by a combination of all.

Paying the Specialist

In the Jones case, the physical examination of Mr. Jones would be handled by his general practitioner who, co-operating with the health

President Truman with Carl Thompson, Stoughton, Democratic candidate for Governor of Wisconsin in 1948.

insurance organization, might get a fee fixed by the board for his service. But, if he found that Mr. Jones suffered from a heart ailment, he might send the patient to a specialist for further examination.

This specialist might be a high priced man, whose rates were higher than those set by the insurance agency for the service. If so, the agency would pay its fixed amount for the service and John Jones would have to pay the balance out of his own pocket, just as in group hospitalization any services above the limit set by the policy must be paid by the individual patient.

The doctor would decide, himself, whether he wished to co-operate with the plan and would have the right to refuse patients. About 8% of the British doctors still are not under England's health plan, which is more tightly controlled by the government than is proposed by the Truman plan. United States planning officials expect that most American doctors would co-operate. If they did not, the program would collapse.

For some doctors, the plan might reduce incomes. For others, in depressed areas, it would insure a stable income. It would tend to level off fees. It would cut down the amount of free time doctors give to clinics. But planners think there would be less need for clinics under a health insurance plan.

If health insurance reaches only the families of those now covered by the social security plan, it would serve 85 million persons. But those who are shaping the plan hope that a stamp tax arrangement can be worked out to give health insurance to 125 million.

Many problems remain to be worked out. There are local shortages of doctors, dentists, nurses and hospitals, and health insurance would add to the demand for service.

Government Plans to Correct Shortages

There are fewer than 200,000 doctors in the United States. Of these, about 150,000 are practicing physicians. The others are in public health service or teaching. About 40,000 or 50,000 more are described as needed before the health insurance plan could be put into operation. There are just as great shortages of dentists and nurses. And there are not enough hospitals.

To remedy these shortages, the government proposes to subsidize training in these professions. It wants to expand teaching facilities. It wants to encourage doctors to move to shortage areas. And it is spending 150 million dollars this year in subsidies to states to help build hospitals. More is to be spent for this later.

Because of the shortages, the program would be curtailed in the beginning. Little help could be given for dentistry. Time limits would be set on the stay of patients in hospitals.

Cost of the program is hard to arrive at. It is estimated that Americans spend about seven billion dollars a year for doctors, hospitals and medicine. But the estimates say that only one family in five has adequate medical care. Some argue that the plan would cost 17 billion dollars a year. Government officials deny this.

Propose 3% Pay Roll Tax

Oscar Ewing and the organization he heads, the federal security agency, still are busy with calculations. They say the larger part of the cost would be met by a 3% pay roll tax, half paid by worker and half by employer. But they add that there is no way of knowing just what the cost would be until the plan is tried. There is a suggestion that any part not paid by the pay roll tax be drawn from general funds in the federal treasury. The British have found that their costs outran early estimates.

Adoption of the plan would take 10% of pay rolls under $3,600 for social services; 3% for health; 4% (by 1952) for old age pensions, and 3% for unemployment insurance. On top of these, there also are plans for temporary disability insurance and some other types of aids.

LOAN PACKETS

Loan packets are available at the State Medical Society office on compulsory health insurance, voluntary health plans, school health, preventive medicine and other health topics. Write today. Place a set in your local public library.

SEN. DOUGLAS PROPOSES DEDUCTIBLE PLAN FOR "CATASTROPHIC" ILLNESSES

Washington, D. C., Jan. 14.—Only a day before he entered a Washington hospital himself, for treatment of a war wound, Senator Paul H. Douglas (D., Ill.) told reporters of his idea for a deductible type of health insurance for "catastrophic illnesses."

Sen. Douglas introduced the bill in the hope of breaking what he termed a "deadlock between the extremisms of the Administration's plan on the one hand and of the voluntary plans supported by the AMA on the other."

His plan, while not yet introduced in Congress, would pay all of the medical and hospital bills in excess of 5 per cent of a family's income, or $150, whichever amount is lower. Salaried workers would pay one-half of one percent of their pay with the employers contributing an equal amount. The self-employed would pay the full 1 per cent of gross income.

Many Objections

Sen. Douglas indicated he would like to see the administration of his plan turned over to Blue Cross and Blue Shield in the interest of decentralization. He argued that the AMA would "merit strong criticism" if it did not support his proposal.

The merits of the proposal have stirred up a considerable amount of controversy. Dr. Louis H. Bauer, New York, chairman of the board of trustees of the AMA, said in a press conference on Dec. 9 that he doubted "the government will ever permit voluntary plans to use federal funds."

The Washington Post editorialized on Dec. 10: "We suspect Sen. Douglas' plan for $150 deductible health insurance would be about as acceptable to the American people as an influenza epidemic."

Major objections raised by the Post were that "if any compulsory system is to be enforced, the benefits should be general," who would determine the income of families, how could transitory employees keep track of their earnings, and in a period of economic adversity, the trend would be away from the $150 deductible provision to government coverage of all medical expenses.

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AMERICAN MEDICAL ASSOCIATION 12-POINT PROGRAM

Wisconsin Lists Accomplishments on Many Points

A FEDERAL DEPARTMENT OF HEALTH

1. Creation of a Federal Department of Health of Cabinet Status with a Secretary who is a Doctor of Medicine, and the coordination and integration of all Federal health activities under this Department, except for the military activities of the medical services of the armed forces.

WISCONSIN: This is a national development, but one that has been recommended by the AMA since 1884.

MEDICAL RESEARCH

2. Promotion of medical research through a National Science Foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.

WISCONSIN: Both the University of Wisconsin Medical School and Marquette University School of Medicine receive grants from the United States Public Health Service for medical research. Over $25,000 yearly from state funds goes to the University of Wisconsin for cancer research, $55,000 annually from the Wisconsin Alumni Research Foundation with added amounts to several departments for related research, and many thousands of dollars from trust funds and bequests are ear-marked for various specific research. Similar amounts are available to Marquette University from the United States Public Health Service, bequests and trust funds. County-wide research projects by local medical societies are encouraged by the State Society.

VOLUNTARY INSURANCE

3. Further development and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with extension as rapidly as possible into rural areas. Aid through the states to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans with local administration and local determination of needs.

WISCONSIN: The State Medical Society began experiments with voluntary prepaid hospital and surgical care plans as early as 1937. Experience with these plans resulted in the formation of Wisconsin Physicians Service (Blue Shield) in 1946. On December 1, 1949, it provided surgical, maternity and medical coverage to more than 160,000 persons. The nation's first medical society sponsored voluntary plan operated through private insurance carriers, was developed by the Society. It is the Wisconsin Plan, which now covers more than 225,000 persons. A local Milwaukee County Medical Society plan reports over 195,000 coverage in Milwaukee County. Both the Blue Shield plan and the Wisconsin Plan make their coverage available to people in rural areas, single family units and individual subscribers.

MEDICAL CARE AUTHORITY WITH CONSUMER REPRESENTATION

4. Establishment in each state of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.

WISCONSIN: This concerns the establishment within each state government of an agency to receive and administer any funds coming to the state as the result of federal legislation for the medical care of the medically indigent as part of an over-all program to provide comprehensive medical care for the American people on a locally administered basis.

NEW FACILITIES

5. Encouragement of prompt development of diagnostic facilities, health centers and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.

WISCONSIN: The Hospital Survey and Construction Act is administered in Wisconsin by the State Board of Health. At present 35 hospital projects are actually underway, mostly in rural areas, and a total of $6,000,000 in federal aid has been allotted to these projects. The medical society has supported this program and legislation to improve its administration. It has also sponsored legislation for the development of diagnostic and convalescent facilities for rheumatic fever and cancer victims.

PUBLIC HEALTH

6. Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

WISCONSIN: The efforts of the State Board of Health in the field of communicable disease control has made Wisconsin one of the "healthiest" states in the nation. Small pox, typhoid and diphtheria are virtually non-existent, the state has one of the lowest V-D rates in the nation and there is

every prospect that tuberculosis may be completely eradicated in little more than a decade. A new State Laboratory of Hygiene to provide additional modern laboratory services to rural physicians was authorized by the legislature at the request of the State Medical Society. The Society is continuously supporting the establishment of local health units in county and city–county areas, and legislation to insure adequate salaries for public health officers has been sponsored by the Society.

MENTAL HYGIENE

7. The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.

WISCONSIN: Since 1941 a mental health and hygiene program has been underway in Wisconsin through the State Board of Health with the active support of the State Medical Society. Up to $75,000 a year in federal funds are used to demonstrate what child guidance clinics can do, and local initiative takes over to maintain the clinic thereafter. Twelve such clinics are now operated in the state as the result of this program.

HEALTH EDUCATION

8. Health education programs administered through suitable state and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.

WISCONSIN: The State Board of Health and the State Medical Society devote a majority of their efforts to educational programs to inform the people of available facilities and personal responsibility for health care. Health councils, health meetings and school health programs as well as weekly radio and newspaper presentations on health have accomplished much in the better education of the state's citizens. The medical society's radio program, the "March of Medicine" carries the health education campaign to the people via 25 radio stations.

CHRONIC DISEASES AND THE AGED

9. Provisions of facilities for care and rehabilitation of the aged and those with chronic disease and various other groups not covered by existing proposals.

WISCONSIN: A detailed study of Wisconsin's needs for the chronically ill and aged has been conducted by the State Medical Society. The resulting publicity has created considerable public support for legislation offered in the current session by the society seeking permissive laws for the building of county infirmaries for the aged and chronically ill, and state aid for their maintenance. Many counties solved the problem on a local basis, but others need state aid, and the society is giving its support in every way possible.

VETERANS' MEDICAL CARE

10. Maintenance of existing high standards of medical care for veterans, including extension of facilities where the need can be shown and, where practicable, care of the veteran in his own community by a physician of his own choice.

WISCONSIN: The Veterans Medical Service Agency of the State Medical Society has enabled thousands of Wisconsin veterans to obtain medical care at government expense through the physicians of their choice. In the last 1½ years, more than 21,000 Wisconsin veterans have been served through this agency. The veterans' hospitals in Wisconsin are closely affiliated with the medical schools of the University of Wisconsin and Marquette University as well as private hospitals.

INDUSTRIAL MEDICINE

11. Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highway, home and on the farm.

WISCONSIN: The state's industrial health program is one of the most outstanding in the nation. Through cooperation between the State Board of Health's industrial hygiene unit, in-plant industrial health clinics are held for hundreds of workers and many employers. Great progress in safety and health education has been made as a result. The society's committee on rural health and accident prevention has carried on a constant campaign for safety on the farm, highway and home. Through cooperation with the state workmen's compensation department the society insures that most of the state's industrial workers have the benefit of free choice of physician in industrial accident cases.

MEDICAL EDUCATION AND PERSONNEL

12. Adequate support with funds free from political control, domination and regulation of the medical, dental and nursing schools and other institutions necessary for the training of specialized personnel required in the provision and distribution of medical care.

WISCONSIN: Better distribution of physicians through the preceptorship system of the University of Wisconsin medical school (which has resulted in many physicians locating in rural areas), a physician's location service of the State Medical Society to help bring physicians to communities needing them, and legislation for the appointment of "special medical officers" in sparsely populated areas to perform public health duties and encourage them to establish a private practice in those areas.

AMA Takes Position on Pending Health Legislation in Congress

Washington, D. C., Dec. 15—The American Medical Association has reviewed its position on pending legislation which is scheduled for early vote in Congress in the opening days of 1950. During the clinical session of the AMA, Dec. 6–9, Washington, the House of Delegates discussed many bills and some became targets for which resolutions were aimed.

Dr. Jos. S. Lawrence, director of the AMA's Washington office, recently issued a year-end legislative appraisal presenting the bills of major concern to the medical profession, their status in Congress and the latest official AMA position on each bill. This legislation is listed below:

DR. LAWRENCE

National Health Legislation

S. 1679—Introduced by Mr. Thomas (D.—Utah) and 7 other Democratic senators.

Chief Provisions: Presents the Administration program to provide medical care to approximately 85% of the population through national compulsory health insurance. Wages up to $3,600 annually would be taxed 3% initially and treasury funds could be drawn upon to bear additional cost. Medical care would include such services as medical, dental, and hospital (up to 60 days). Those who furnish services would be paid from the fund.

Other Provisions: This bill provides for Federal programs to assist states in education of health personnel, medical research (this would be entirely Federal), hospital construction, special aid for rural and other shortage areas, local public health units, research in child life and grants for maternal and child health and crippled children's services.

Status: Hearings held in Senate and House—adjourned indefinitely.

A. M. A. Position: Opposed.

S. 1456—Introduced by Mr. Hill (D.—Ala.), 2 Democratic and 2 Republican senators.

Chief Provisions: Would establish a program of aid to states in assisting persons to meet the cost of medical care, including 60 days hospital expense, outpatient clinic services in hospitals or a diagnostic clinic. Would be accomplished by encouraging persons to purchase non-profit, prepayment plans for hospital and medical care. Federal funds would be apportioned to the several states and with matching state funds persons not able to afford any or all of the cost of such insurance would be subsidized. All persons covered would be entitled to a service card.

Other Provisions: Provides for surveys of the need for additional diagnostic facilities, domiciliary facilities, and of means to attract practicing physicians to rural areas.

Status: Hearings held in the Senate and recessed indefinitely.

A. M. A. Position: The spirit of the bill has been approved.

S. 1581—Introduced by Mr. Taft (R.—Ohio) and 2 other Republican senators.

Chief Provisions: Proposes Federal funds to assist the states in providing general health, hospital, medical, and dental services for persons unable to afford the whole cost thereof. State programs would subsidize those unable to pay the whole cost of the voluntary insurance plan.

Other Provisions: Provides Federal aid to states for school health services, establishment of local public health departments, increasing medical personnel, offering inducement to physicians and dentists in rural areas, and assisting in hospital construction.

Status: Hearings held by Senate Committee and recessed indefinitely.

A. M. A. Position: Spirit of the bill approved.

S. 1970—Introduced by Mr. Flanders (R.—Vt.), and Mr. Ives (R.—N. Y.).

Chief Provisions: Would distribute Federal funds through state programs to enable persons to purchase voluntary health insurance at rates which they can afford—subsidies from partial to total cost for sub-income persons. Subscription charges will be scaled to income instead of flat rate premiums—the maximum income limit would be $5,000.

Other Provisions: Would provide Federal funds to states for aid in hospital maintenance, construction of health service centers, training of medical personnel, hospital construction, local public health units, paying medical personnel in needed areas, and providing traveling clinics. By 1953 it is estimated that the total cost per year would approximate $850,000,000.

Status: Senate hearings held and recessed indefinitely.

A. M. A. Position: Spirit of the bill approved.

Social Security Legislation

H. R. 6000—Introduced at the request of the Administration by Mr. Doughton (D.—N. C.).

Chief Provisions: Presents for the Administration its version of liberalization and extension of the present Social Security Law. Approximately eleven million persons are to be added to the rolls, including the self-employed, certain household domestics, salesmen, and others (physicians are not included.) The bill further provides for raising the maximum taxable portion of wages to $3,600. A new category of coverage included in the bill is the section which provides for compulsory contributions for permanent and total disability insurance. The Board of Trustees has directed opposition to the bill while this section is included.

Status: Passed the House of Representatives October 5, 1949, under a closed rule and sent to the Senate Finance Committee where hearings will be scheduled in the early part of 1950.

A. M. A. Position: Opposed to that section of the bill which provides for compulsory contributions for total and permanent disability because it is believed that this provision would be an entering wedge for socialized medicine. Testimony will be offered at the hearings to be scheduled by the Senate Finance Committee in early 1950.

Aid to Medical Education

S. 1453—Introduced by Mr. Pepper (D.—Fla.).

Chief Provisions: Provides Federal funds for grants to schools (including schools of medicine, osteopathy, dentistry, nursing and sanitary engineering), on the basis of (in the case of medical schools) $500 for each student up to normal enrollment and an additional $500 for those enrolled in excess of normal. Provides Federal funds also for construction of new facilities on a matching basis. Schools of osteopathy are included on a basis equal to medical schools. A scholarship provision is included when enrollment of students is less than the normal capacity.

Status: Passed Senate September 23, 1949, and referred to House Interstate and Foreign Commerce Committee. The House companion bill, H. R. 5940, was favorably reported from the Interstate and Foreign Commerce Committee on October 11, 1949. H. R. 5940 amends the language of S. 1453 in that it includes not only schools of osteopathy but also schools of optometry. The House bill will be before the Rules Committee in the opening days of the session.

A. M. A. Position: Opposed on several grounds, chief of which is the threat of Federal control of schools. This decision was made by the House of Delegates at the interim session.

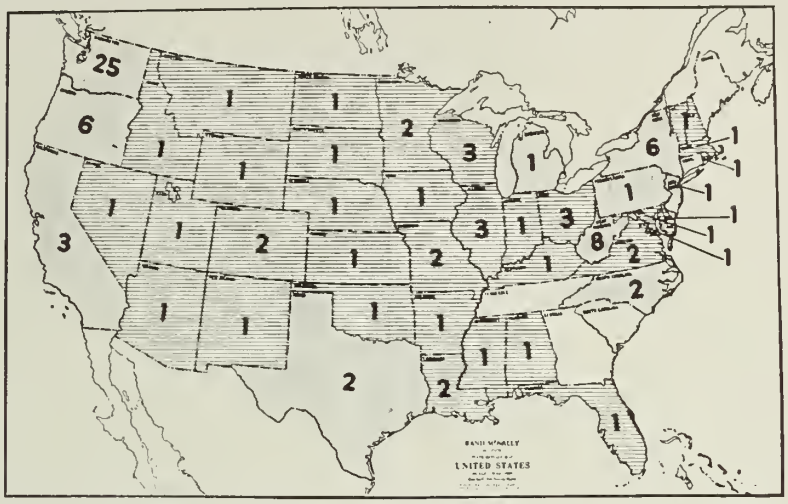
School Health Services

S. 1411—Introduced by Mr. Thomas (D.—Utah) and 13 other senators.

Chief Provisions: Presents the Administration's $35,000,000 program for aid to states in providing health examinations and treatment for children of school age (between ages 5 and 17). Section 6, paragraph 1 (C) states that state plans "may provide for the prevention and treatment of such physical and mental defects and conditions for all school children." Such language would mean that children whose parents could afford the services of a family physician would still be entitled to free treatment, including surgical services. This, in the opinion of the A. M. A., constitutes socialized medicine for children.

Status: Passed Senate April 29, 1949, and referred to the House Interstate and Foreign Commerce Committee where it is now pending.

A. M. A. Position: Opposed so long as it includes the clause (C) providing services to all children regardless of economic status of parents.



VOLUNTARY HEALTH PLANS are operating in every state. Figures indicate number of plans in each state. Tennessee, Georgia, South Carolina, Maine and Connecticut have plans in the making or just started operation.

Voluntary Plan Enrollment Rises Rapidly in Wisconsin

Madison, Jan. 16.—Nearly 1,000,000 persons in Wisconsin are now enrolled in voluntary prepaid health care plans endorsed or operated by Wisconsin physicians or hospitals, according to the state medical society.

Wisconsin Physicians Service, the Blue Shield plan of the state medical society, reports 158,000 persons covered for surgical and medical benefits as of Jan. 1. A local Milwaukee county medical society sponsored plan covers another 220,000 persons, it is reported. Blue Cross, the voluntary hospital care plan, covers about 750,000 persons in the state. However, most Blue Shield members are also covered by Blue Cross. Thus there is a duplication of coverage and the enrollment of the three programs cannot be totaled for an accurate figure of coverage.

The Wisconsin Plan, a health care policy sold by private insurance companies under state medical society approval and endorsement, has enrolled more than 203,000 persons.

Nationally, the picture shows the same wide pattern of coverage. The National Council for Economic Security, Chicago, estimates that more than 60,000,000 persons have hospital benefit insurance; 35,000,000 have surgical protection, and 15,000,000 have medical benefit policies.

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THEY STOOD UP TO BE COUNTED

A total of 62 organizations in Wisconsin have publicly announced their intentions of opposing compulsory health insurance through resolutions sent to their Senators and Representatives. They are:

Wisconsin State Chamber of Commerce
Wisconsin State Dental Society
Wisconsin Federation of Women's Clubs
Associated Women of Portage County Farm Bureau
Wisconsin State Dental Hygienist's Association
Associated Women of Jefferson County Farm Bureau
State Medical Society of Wisconsin—House of Delegates
Lancaster Association of Commerce
Farm Bureau Federation of Wisconsin
Wausau Chamber of Commerce
Wisconsin Canner's Association
Reedsville Chamber of Commerce
Milwaukee Hospital, Board of Directors
Appleton Chamber of Commerce
Washington–Ozaukee County Medical Society
Kenosha Chamber of Commerce
Northwest District Dental Society
Door County Farm Bureau
Central Wisconsin Dental Society
Trempealeau – Jackson – Buffalo County Medical Society
Milwaukee County Dental Society
Monroe County Medical Society
Fox River, Component to Wisconsin State Dental Society
Dodge County Farm Bureau
Kenosha County Dental Society
Grant County Bar Association
Fond du Lac County Dental Society
The Saturday Club, Beloit
Sheboygan County Farm Bureau, Plymouth
Clear Lake Veterans of Foreign Wars Post #5828
Wisconsin Rapids Chamber of Commerce
Gerald George Graham Post #1853
Green Lake County Farm Bureau
Alpha Circle, Richland Center
Green Lake County Farm Bureau of Associated Women
Clark County Farm Bureau, Greenwood
VFW #5612, Plymouth
Jefferson County Dental Society
La Crosse County Bar Association
Thursday Study Club of Women, Warren
Milwaukee County Farm Bureau
Chippewa Falls Chamber of Commerce
VFW Denmark Community Post #6705
VFW Otto Oas Post #659, Manitowoc
Dodgeville Women's Club
Jefferson County Medical Society
Shawano County Medical Society
Cogitata Federated Club, Baraboo
Eubank–Vleick–Zuelke VFW Post, Westfield
Superior Woman's Club
Waukesha Women's Clubs
Greenwood Woman's Club
Economics Club, Neenah–Menasha
Clarence Keske VFW Post, Beaver Dam
Fortnightly Club, Milton Junction
New Holstein Civic Society
Woman's City Club, Milwaukee
Practical Club, Waukesha
Geneva Lake VFW Post, Williams Bay
City Federation of Women's Clubs, Edgerton
Twentieth Century Study Club, Beloit
Boscobel Chamber of Commerce

Hawley Leaves Post With Blue Cross–Blue Shield

Chicago, Jan. 4—Dr. Paul R. Hawley has resigned his position as the chief executive officer of the Blue Cross and Blue Shield Commissions to become director of the American College of Surgeons, effective March 1.

DR. PAUL R. HAWLEY

He will retain the presidency of Blue Cross' Health Service, Inc., which was chartered in November as a national insurance company designed to offer uniform benefits to employees of large industrial and business organizations operating in the areas of several of the 90 Blue Cross plans.

COMMENTS FROM THE WISCONSIN PRESS

"This country has a medical care problem. But it is a problem which is being soundly solved through such devices as the competitive voluntary systems. Regimented medicine, which would be the overture to socialized medicine, would be the most dangerous possible answer."

—Evansville Review, Dec. 22, 1949

* * *

"Experience may not always be the best teacher, but certainly there are lessons to be learned from the operations of the socialized medicine system in England. Perhaps the most profound lesson is that nationalization of the health program does not improve medical service to the people. On the contrary, it disorganizes the service and brings a lower standard of performance. Ultimately this affects the health of the nation adversely."

—The Marinette Eagle Star, Dec. 14, 1949

"The principal argument used in favor of compulsory government health insurance is that there is no other way of protecting most people against the exigencies of illness. Yet the spectacular growth of the voluntary health insurance plans in recent years refutes this idea completely."

—New London Press Republican, Dec. 1, 1949

* * *

"Far better than any scheme for socialized medicine under bureaucratic Federal control is the concerted action of leading medical and welfare associations which has just been undertaken to *'improve the nation's health.'*

. . . By their formation of the Inter-Association Committee on Health, the medical and related professions have assumed a position of constructive leadership that is rightfully theirs."

—Milwaukee Sentinel, Nov. 19, 1949

EXPECT "SHOWDOWN" ON HEALTH IN 81st CONGRESS

Piecemeal Enactment of Health Measures Seen

As the Congressmen take up their posts this month on Capitol Hill there is every indication that medical and hospital care will take a front role among domestic issues up for debate.

Numerous developments in recent weeks give strong indication that potent medicine is brewing in the Eighty-first Congress for the physicians of the country.

Humphrey Reveals Strategy

Some of these developments: Federal Security Administrator Oscar Ewing's health inspection tour of Europe; Sen. Paul Douglas' plan for a "deductible" type health insurance bill that is being hailed as a "compromise" measure, and the American Medical Association has taken a definite stand in opposition to pending legislation for federal aid to medical schools, school health and social security.

Last October when Sen. Hubert Humphrey, Minn., said he wouldn't vote for compulsory sickness insurance until a better plan was devised, he also revealed the Administration's strategy for 1950 by urging that "the other titles of S. 1679 should be enacted before adoption of Title VII—compulsory sickness insurance."

Majority leaders in both the House and Senate, are expected to press for "showdown' votes on as many of those titles and other issues as possible, with an eye to campaign ammunition for the elections next fall. If they are successful, the field will be cleared for an intensive, single-issue fight on compulsory health insurance in the presidential campaign in 1951.

Murray Noncommittal

Senator James Murray (D., Mont.) told the press on Dec. 16 that he thinks federal medicine won't pass in 1950, but carefully refrained from predicting that Administration forces will not try to get a show of hands as frequently as possible on both the related and main issues this year, according to Gerald Gross, editor of Washington Report on the Medical Sciences.

DR. W. S. MIDDLETON

Middleton Task Force Tackles Reserve Problem

Washington, D. C., Nov. 22—A special task force under the direction of Dr. W. S. Middleton, Dean of the University of Wisconsin Medical School, has begun hearings on civilian reserve problems of the armed forces medical services as a preliminary step in the Department of Defense's effort to correct deficiencies in the program.

The task force will inquire into various phases of medical services reserve activities as they now function, and will hear statements from a number of military and professional organizations. Its findings will be transmitted to the Armed Forces Medical Advisory Committee, which was recently appointed at the insistence of the American Medical Association.

College of Surgeons Has Home in Chicago

Chicago, Dec. 23—An international home is now available to all surgeons with the establishment of the Domus Medica at the International College of Surgeons headquarters, 1516 Lake Shore Drive, Chicago, it has been announced by Dr. Valentin Charry, associate secretary.

The headquarters will offer a great variety of scientific information, service and assistance as well as general cultural and traveling facilities. Members of the College will be able to participate in postgraduate courses, monthly conferences and meetings, and hospital and research center inspections.

Sen. Hill to Renew Drive for "Voluntary" Bill

Chicago, Dec. 3—Senator Lister Hill (Dem., Ala.) promised that he will renew his efforts this year to secure Congressional enactment of the voluntary health insurance bill which he introduced last spring.

At the dedication of a new hospital constructed under the Hill-Burton program, Senator Hill said "This integration of your hospital and health insurance facilities is especially gratifying to me because it carries out the very basic objective of my voluntary health insurance bill."

The hospital being dedicated is integrated with the health insurance plan of an Alabama manufacturing concern. Senator Hill continued, "What you are doing bears out our faith in the voluntary methods of our democracy and supports our confidence in the ability of the people to act for themselves and to provide medical care for themselves without compulsion or reliance on a socialized system."

AMA Conducts Its Own Study of British Health

Chicago, Dec. 17—Two members of a committee of three—Dr. Loren R. Chandler, San Francisco, Dean of Stanford University School of Medicine, and Dr. Harold Diehl, Minneapolis, Dean of Medical Sciences at the University of Minnesota—left recently for England to study medical education as it exists under health legislation started by the Labor government.

Dr. Stanley Dorst, Cincinnati, Dean of the University of Cincinnati College of Medicine, will join the others in London in a few weeks. The committee will report to the Board of Trustees of the AMA.

A second group will go to England soon to make a factual study for the AMA of the effect of the National Health Service Act of Great Britain on the people of that country. The group will consist of a surgeon, an internist, general practitioner, pediatrician and an industrial physician. Their report to the Board of Trustees will cover broad aspects of medical care under socialism.

HELLO WISCONSIN

(A reprint of part of Editor William T. Evjue's column in the Capital Times on Jan. 17, 1950)

By WILLIAM T. EVJUE

January 17, 1950

• A READER encloses a letter to The Capital Times which was recently sent out by the State Medical Society of Wisconsin and which was signed by its president, Dr. John W. Truitt. The letter follows: "From the 'cradle to the grave' the British citizen has a so-called 'guarantee' of security. Yet today he is one of the most insecure of all people. In spite of the highest taxes in the world, and billions of dollars from the United States, Britain finds herself in a real crisis. And many Americans are thinking of imitating the costly and hazardous social and economic schemes with which the Briton has saddled himself. We feel you will be interested in reading the enclosed collection of articles 'Utopia on the Rocks' to discover how British socialism is actually working in practice. Do we want to embark on similar paths? Is it what we want from government? These are questions we must soon answer if we are to properly evaluate the desirability of the 'welfare state.' Frankly, it will take you about 45 minutes to read Mr. Leech's series of articles, but we'll almost bet our right arm that you'll find them informative and stimulating—well worth reading. We hope, you will read the series and then give a little thought to just how much real security there is in state security."

* * *

• ACCOMPANYING THIS letter was a pamphlet containing a series of articles written by E. T. Leech, editor of the Pittsburgh Press, who spent some time in England and wrote the series under the heading "Utopia on the Rocks—A Report on British Socialism in Action." It should be recorded here that the Pittsburgh Press is a member of the conservative Scripps–Howard chain of newspapers that supported Dewey in the last campaign. The Capital Times does not question the right of the medical profession to fight a program that it honestly believes is against the best interests of the American people. We do wonder, however, how the medical profession squares its present fight on the health insurance program with its code of ethics which proscribes the profession from entering the field of partisan politics as a profession. The American people are today demanding that the best medical care shall be placed within reach of the average American family. The American Medical association and its satellites are not going to squelch this legitimate demand by joining with the Republican leadership in seeking to discredit these demands by yelling "socialism" or seeking to make "the welfare state" a term of opprobium.

THE VOICE OF MEDICINE

Dr. Charles H. Parkes, Sharon, to the Sharon Woman's Club—Nov. 18:

"It is incomprehensible to us that there has developed here the idea of following England into socialized medicine . . . in England . . . a hospital with an 18 months' waiting list finally got empty beds. It sent out an ambulance for three separate applicants, only to find that all were long since dead. The offer of something for nothing may exercise a temporary attraction, but its benefits are exaggerated if the citizen dies before he can cash in on his claim."

* * *

Dr. Robert Handeyside, Palmyra, to the Jefferson County G. O. P. meeting—Dec. 15:

"If government medicine would improve the quality of medical care it might be worth the cost . . . but we know what happened with the quality of medical care in other countries which have adopted socialized medicine . . . It impairs medical ethics, corrupts the practice, causes malingering and prevents adequate time for diagnosis.

* * *

Dr. Karl H. Doege, Marshfield, to the Marshfield Woman's Club—Nov. 15:

"The health insurance proposal is part of the vast social security plan advocated by President Truman . . . If Congress approves the Truman proposal, the complete social security program will cost the American people one and a quarter trillion dollars in the next 50 years . . . This is enough money to pile seven stacks of silver dollars up to the moon and have enough left over to pay the entire national debt and all personal income taxes paid during the 1948 fiscal year."

* * *

Dr. W. D. Stovall, Madison, to the Catholic Woman's Club of Watertown—Nov. 9:

"Advocates of socialized medicine would materialize medical care by robbing it of its spiritual values, claiming that such a course would put medical care within the reach of everyone, but contrary to this claim, the individual would have to pay more for care that would not meet his individual needs."

* * *

George H. Hipp, Wausau, to the Catholic Woman's Club of Wausau—Nov. 7:

"Let's face the cold, solid fact that if any one of the fields of medicine, insurance, housing, banking or public utilities falls under the heels of collectivism, the rest will quickly follow, and we must make a choice between free enterprise or collectivism. As government dealings grow larger and larger the individual grows smaller and smaller."

* * *

Mrs. Robert Fitzgerald, Milwaukee, to Brown–Kewaunee–Door Medical Society Auxiliary meeting—Dec. 9:

"Compulsory health insurance is one of the final, irrevocable steps toward a regimented state . . . The cost of the compulsory health insurance program would be met by six to ten per cent deductions from individual salaries . . . Veterans entitled to free medical care will be taxed as well as members of faith healing religions. People who are already protected under satisfactory voluntary health plans will also be taxed, doubling or trebling the medical bill of the average family."

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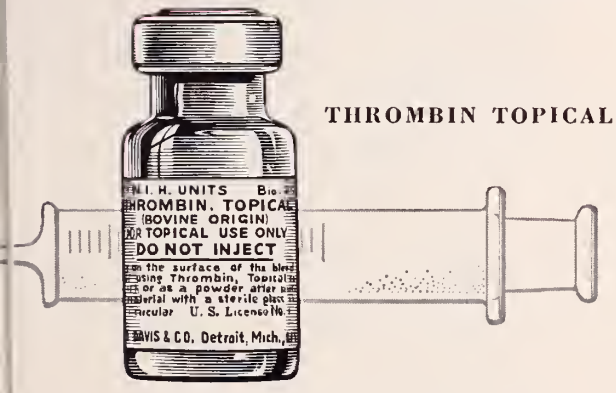

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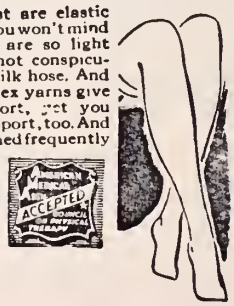

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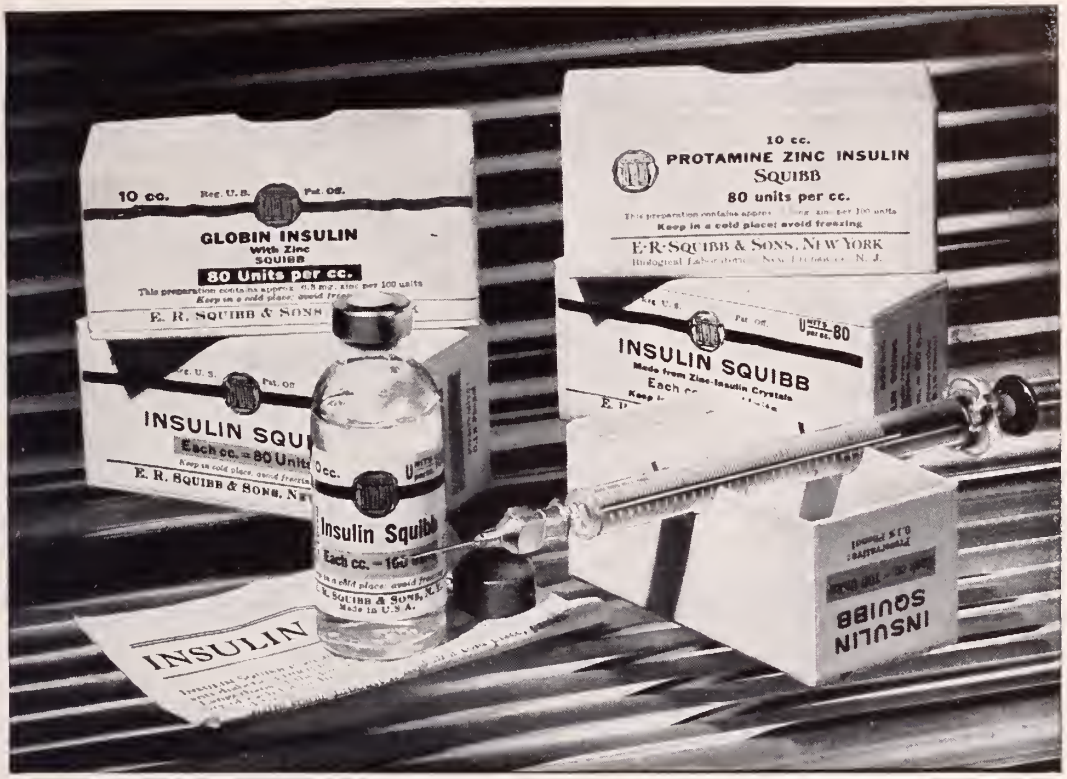

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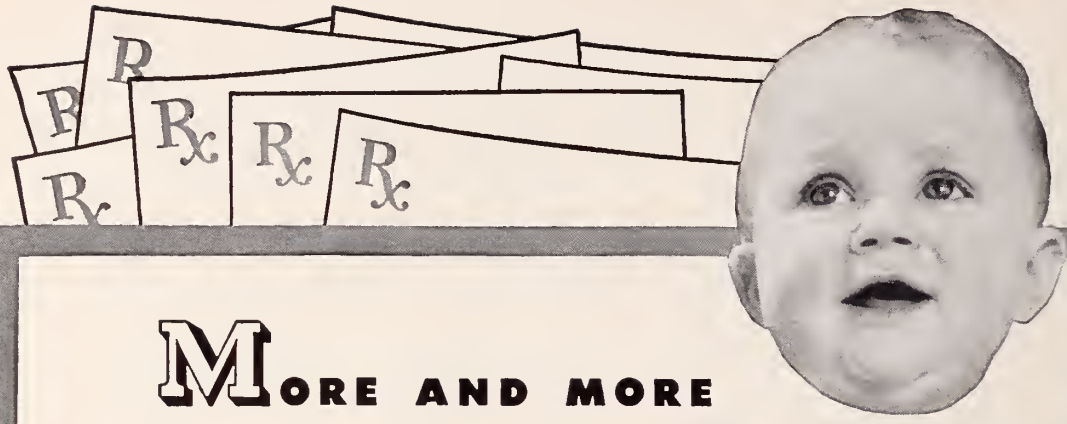

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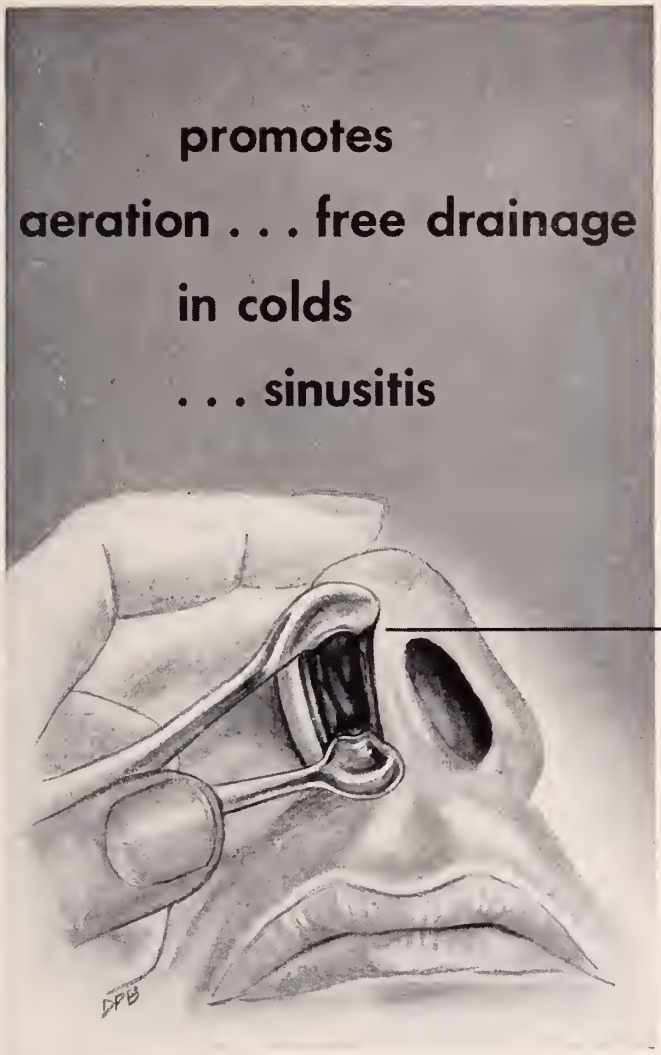

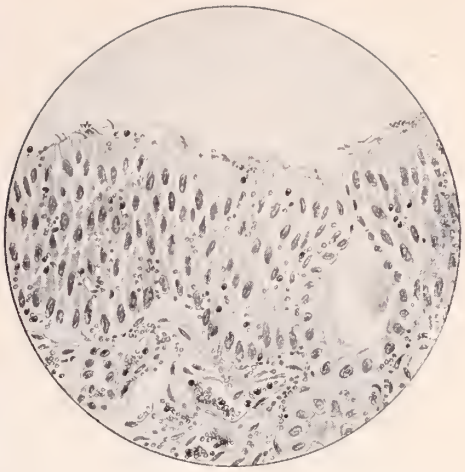

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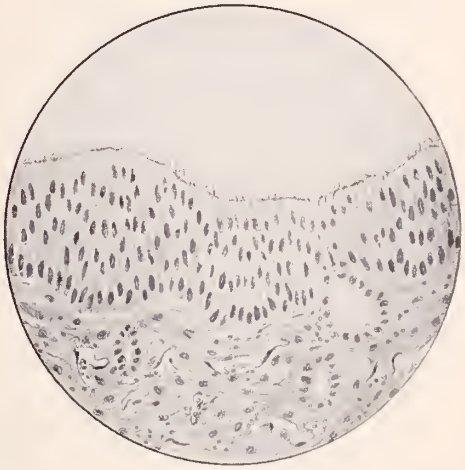

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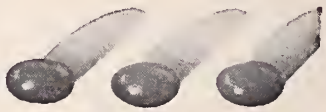

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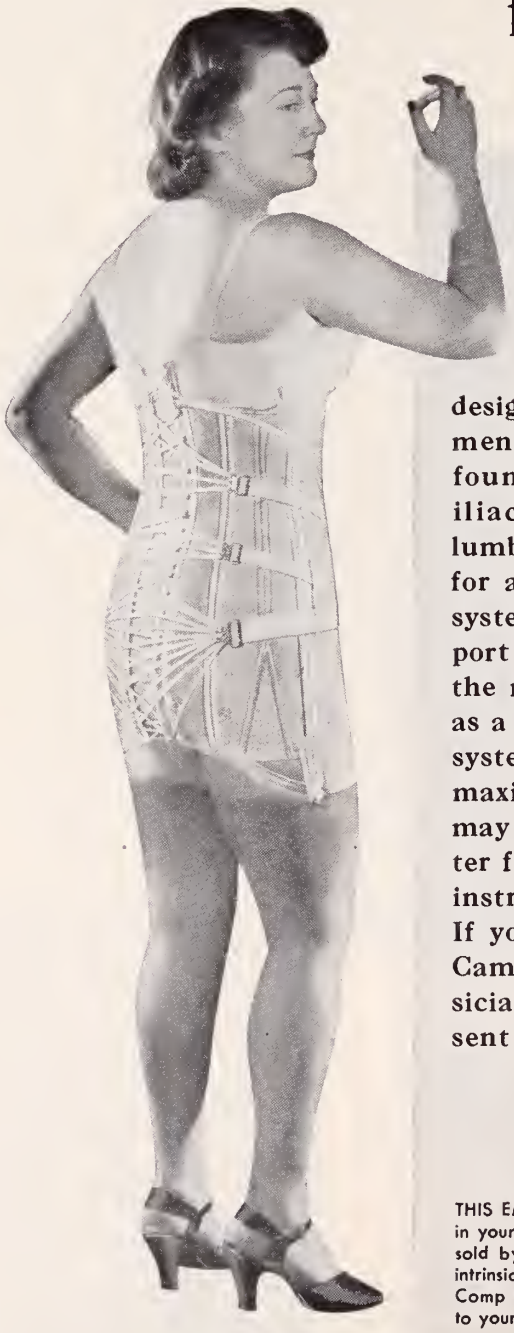

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« « « EDITORIALS » » »

Blood Groups and Hemolytic Reactions

Knowledge is acquired in such small pieces over so long a period of time that great caution is necessary for its technical application. This is exemplified in all fields of human endeavor, but it is particularly true in the practice of medicine. For the past fifty years knowledge concerning blood groups and blood compatibility within the human family has been accumulating in such small fragments that development of technical practice has been fraught with hesitation and some danger. It was not until Landsteiner had discovered the A and B factors in the red cells of blood that the significance of antibody-antigen reactions was associated with hemolysis and the cause of individual incompatibility of blood was recognized.

Even though, as we now know, this knowledge was only the beginning of the development of a large body of knowledge on the incompatibility of blood there quickly came into practice technical procedures for grouping and cross matching blood. By these technics all bloods were grouped into one or another of the recognized four groups, AB, A, B, O, and compatibility determined. To still further simplify this technic Moss classified the different groups as group I, II, III, or IV, and Jansky used the same identification marking but reversed the position of the Moss groups I and IV. This was all done in a spirit of definitive knowledge, and the use of whole blood began to be used as a therapeutic agent.

For several reasons it soon became evident that either the knowledge was fragmentary or the technic was poorly applied. Doubtless both contributed to the occasional reaction which followed the transfusion of whole blood.

But, of the two sources of error, the more important one was the incompleteness of knowledge. At this stage all blood was classified into one of the four recognizable groups, AB, A, B, or O, and used with confidence. When a reaction occurred following what was proved to be compatible blood by recognized test, it was attributed to technical error without any suspicion that it might be due to inadequate knowledge.

As time has passed and more information has accumulated, the fragmentary nature of the earlier knowledge has become apparent. Instead of two

antigenic blood factors, now a number of factors are known; each one of which contributes to the incompatibility of individual bloods and not only to the danger of blood transfusions but also to the long recognized but poorly understood hemolytic disease of the newborn. The more recent studies have revealed not only a number of these antigens but that they occur in one combination or another which contributes to the 5,000 recognizable human blood types.

Not all of these factors are important to clinical medicine so far as we know, but one of the most recent ones, Rh, has turned out to be not only of major significance to the satisfactory and safe use of whole blood for transfusion therapy but also to the pathogenesis of hemolytic disease of the newborn. Its presence was first recognized by Dr. Philip Levine in 1939. He detected an atypical agglutinin in the blood of a mother who had just given birth to a dead fetus. He called this agglutinin "atypical" because it did not unite with any of the known erythrocytic antigens. Further study revealed that it reacted with 83 out of 104 group O persons. Very soon after this, 1940, Landsteiner and Weiner reported the occurrence of a hither-to unrecognized antigen in the red cells of 85 per cent of Europeans which was similar to a factor in the red cells of the Rhesus monkey. Because of this similarity, they designated it Rh.

This added another antigen factor to the already numerous ones formed in erythrocytes. It provided the basis for still further broadening of the classification of blood. What in the beginning seems simple became complex as knowledge accumulated. At first, as in the case of the A,B factors, blood with reference to Rh was grouped simply as negative or positive, and it was found that 85 per cent of white people in this country are positive and 15 per cent are negative. But again it was soon apparent that Rh was not a single substance. It was found to occur in three types, Rh′, Rh_0, Rh″, which combined to form eight types of blood, Rh, Rh′, Rh″, Rh′Rh″, Rh_0, Rh_0 Rh′(Rh_1), Rh_0Rh″ (Rh_2), Rh_0 Rh′Rh_0Rh″ (Rh, Rh_2).

Since blood factors and, therefore, blood groups and types are the result of the action of genes, they occur according to the mendelian laws of heredity. The genotype pattern for this occurrence has been worked out by Fisher and its validity has been supported by Race and other workers.

The symbol Rh was not found suited to symbolizing the genotype patterns and Fisher substituted for it single letters. Thus C is Rh′, D is Rh_0, and E is Rh″. The antiserums, agglutinating serums, for the three types of blood cell factors are anti C, anti D, and anti E. When either one or all of these factors are absent from the chromosomes, the place is taken by an alternative factor which has been designated c, d, e, or cde, as the case may be.

There are in man 24 chromosomes. And each person has a pair of these 24 different kinds, the father contributing one of each pair and the mother the other one. The homozygous person has a gene for the Rh factor in each one of the pair of chromosomes, and by Fisher this is designated genotype DD. The heterozygous person has a gene for the Rh factor in only one of the chromosomes of the pair and is designated genotype Dd. Both the homozygous and heterozygous persons are blood group Rh positive, but their significance to siblings is different. The blood group Rh negative individual has an absence of genes for the Rh factor in both chromosomes, the one from the father and the one from the mother, is therefore labeled genotype dd. However, all people are not simply Rh positive, genotype DD or Rh negative, genotype dd. There are eight combinations of C or c, D or d, E or e which can occur in one pair of chromosomes.

As this knowledge has accumulated piece by piece, its application to medical practice has become increasingly important and somewhat more complicated. But, because of the simplicity of the technics by which it is applied and because antiserums for the detection of the most important of these factors is now available. it can be applied in any laboratory where the basic facts from which the tests are derived are familiar to the technician. The blood group and type of any blood are easily and quickly made by any competent and experienced technician. The determinations of homozygosity and heterozygosity cannot be accomplished with certainty, but it can be predicted with an 80 to 90 per cent of accuracy.

While the development of technics for the application of fragmentary knowledge has led at times to defective practices, a body of knowledge has now accumulated—the completeness of which we do not know—which is important in the practice of every physician.

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A seminar in otolaryngology–ophthalmology will be presented by the New York Polyclinic Medical School and Hospital, New York, April 17–21. Recent advances in the diagnosis and treatment of the more common disorders in these fields will be reviewed, with lectures, motion pictures, and demonstrations in the clinics, operating rooms, and dissecting room. Members of the staff of the New York Polyclinic and visiting speakers will participate.

Inquiries concerning the course should be directed to David N. Barrows, Medical Director, New York Polyclinic, 341 West Fiftieth Street, New York 19, New York.

Coccidioidomycosis

Report of a Case with Cutaneous, Osseous, Pulmonary, and Neurologic Manifestations

By CHARLES W. STOOPS, JR., M. D. and STURE A. M. JOHNSON, M. D.
Madison

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THE chronic, highly fatal disseminated type of coccidioidomycosis was described by Posados[1] and Weinicke[2] forty-four years before the more common benign primary pulmonary disease was recognized by Gifford[3] and Dickerson[4]. Since then many excellent reports dealing with the diagnosis, pathogenesis, and clinical course of this disease have appeared.[5-9]

Smith[5] has classified the manifestations of coccidioidomycosis thusly:

I. *Initial or primary infections* (self limited, nearly always respiratory and focalized in the lungs).

(*a*) *Inapparent asymptomatic forms* (the usual type of infection which involves most residents of an endemic area).

(*b*) *Acute respiratory*, "influenzal," or "pneumonic" form (rarely diagnosed in practice).

(*c*) *Either of the above types associated with erythema nodosum or erythema multiforme* (an allergic manifestation frequently associated with joint and muscle pain, known variously as "San Joaquin fever," "desert fever," or "desert rheumatism").

(*d*) *Pulmonary cavity forms* (probably a complication of the acute respiratory type, cavity frequently closing spontaneously but sometimes persisting although the infection is well focalized).

II. *Progressive, "secondary", disseminated infection* (usually highly fatal, known as coccidioidal granuloma, chronic granulomatous coccidioidomycosis, "San Joaquin Valley disease", or "California disease").

The causative organism of coccidioidomycosis is the fungus Coccidioides immitis[10]. It has two phases in its life cycle, a vegetative and a parasitic. The vegetative phase takes place in the soil or on artificial media and is characterized by cottony aerial hyphae which form white, fluffy, moldlike colonies. Reproduction in this phase is accomplished through chlamydospores and arthrospores. The vegetative form of the fungus evidently does not occur in the human body. The parasitic phase occurs in body tissues and reproduces through endosporulating spherules. It has been generally accepted that human infection with Coccidioides immitis takes place only by inhalation of the chlamydospores and arthrospores of the vegetative phase and that coccidioidomycosis does not spread from person to person. However, recent studies by Rosenthal and Routien[11] indicate that the endosporulating spherules of active primary or disseminated coccidioidomycosis are infective and that person to person spread is possible.

After an incubation period of one to three weeks, the initial or primary infection takes place. The clinical picture may vary from an asymptomatic response in 60 per cent of those infected to an acute respiratory form with pleural pain, cough, malaise, low grade fever, chills, night sweats, anorexia, headache, and pharyngitis. In 2 to 5 per cent of those with the initial infection, erythema nodosum, erythema multiforme, conjunctivitis, or severe arthritic pains will develop coincidentally. Thin wall cavities due to necrosis of a pulmonary lesion may be seen. On the tenth to the thirteenth day of the infection a positive skin test to coccidioidin may be obtained as well as positive precipitin and complement fixation tests. Clifford[3] has shown that 75 per cent of the residents of an endemic area have positive reactions to coccidioidin skin tests. Roentgenographic evidence

of the initial infection is usually indistinguishable from bronchopneumonia or primary tuberculosis. Hilar adenopathy and pleural fluid may be found. The pulmonary changes often persist for months or even years.

Spontaneous recovery from primary coccidioidomycosis usually occurs. In less than ½ per cent of the patients with the initial infection there develops, through endogenous reinfection, the progressive and more serious phase of the disease, which has a mortality rate of about 50 per cent. The clinical course of disseminated coccidioidomycosis is varied and associated with a variety of symptoms, pain of all types and locations with fever, cough, malaise, nausea, excessive sputum, various types of paralysis, sweating, coma, and vertigo being found. Physical examination usually reveals weight loss associated with pulmonary findings consisting of rales, consolidation, pleural effusion, and cavity formation. The skin lesions may be papular, nodular, ulcerated, or verrucous. Sinus tracts with ulcerations at the external openings as well as large subcutaneous suppurative granulomatous masses or swellings may be seen. X-ray often will show sharply defined bone lesions with sinus tracts to the skin. Hepatomegaly and generalized adenopathy may be present. A profound anemia is characteristic, and more than 50 per cent of the patients will show an increased sedimentation rate. The coccidioidin skin test as well as the precipitin and complement fixation tests usually elicit positive reactions. Exceptions may exist in disseminated anergic infections.

In many cases of disseminated coccidioidomycosis, the causative organism is easily found in drainage from the sinuses. Biopsy material will show granulation tissue containing large, thick walled, round bodies having four to eight endospores. In rabbits and guinea pigs inoculated with material from the the lesions, the infection will usually develop. Cultures made on Sabouraud's medium will produce a diagnostic white colony in which arthrospores and chlamydospores can be seen microscopically.

Prevention of coccidioidomycosis is not known. The treatment of the benign respiratory form of the disease is symptomatic, with bed rest, salicylates, and iodides being used for relief of joint pain and erythema nodosum. Penicillin and sulfonamides are used to decrease the incidence of secondary infection.

In disseminated coccidioidomycosis many forms of treatment, including sulfonamides, arsphenamines, quinacrine hydrochloride, crystal violet, colloidal copper, thymol, iodides, vaccines, and x-ray, have usually failed. The antibiotics, penicillin, and streptomycin evidently give relief by controlling the secondary invaders. Goldstein[12] reported results by using blood from donors with high precipitin titer to coccidioidin. Excision of isolated areas and drainage of suppurative masses with surgical removal of granulating tissue have usually been satisfactory.

Coccidioidal infection evidently is no longer limited to California and other endemic southwestern states. In 1942, Schenken and Palik[13] summarized 27 cases occurring outside California, and since then similar reports have appeared.[6, 7, 14–22] Since there has been no case of disseminated coccidioidomycosis reported from Wisconsin, it is important to present this case acquired in California but manifested after the patient became a resident of Wisconsin.

Report of a Case

H.A.T., a 33 year old white male was seen at Wisconsin General Hospital on May 25, 1948, for a nonproductive distressing cough associated with nausea, vomiting, weakness, and pain in his left chest of eight weeks' duration. There had been a 25 pound weight loss and a daily temperature of 100 to 101 F. This man had been a wool tier and a cook in the San Joaquin Valley of California during the preceding three years, leaving there in December 1947. The family history revealed that a sister had tuberculosis.

Physical examination disclosed a temperature of 100.6 F., a respiratory rate of 24, a pulse rate of 86, and a blood pressure of 105/60. There was a small indurated, bluish nodule of the posterior, left lateral, scapular area with one small draining sinus. Examination of the chest and heart as well as the rest of the physical examination was within normal limits.

The essential laboratory findings were a hemoglobin content of 10.55 Gm., a red blood cell count of 3,440,000, a white blood cell count of 8,300, a positive blood test for syphilis, and negative sputum studies for tuberculosis. Direct examinations of the material from the draining sinus of his back were negative for fungus and predominate organisms. Cultures showed Staphylococcus albus and no fungus. The admitting chest plate showed a normal cardiovascular shadow and some homogenous density occupying the entire left apical area, with evidence of pleural thickening overlying the upper lobe on this side. There was also some destruction involving the vertebral end of the left second rib. In the remainder of the left lung there was a scattering of soft peribronchial type of density chiefly in the central half and without any distinct nodulation. The hilum shadows were only slightly thickened and not nodular.

On June 11 the hemoglobin content was 9.15 Gm. and the white blood cell count was 9,500. At this time a resection of the head of the left second rib was performed. On going through the muscles, a large abscess communicating with the head of the second rib was opened. This portion of the rib was destroyed. All sinus tracts were curretted and all the necrotic and granulation tissue was removed. Smears and cultures of the granulation tissue removed during the operation were negative for predominant organisms, fungi, and tuberculosis. Microscopic examination of this tissue revealed inflammatory changes. During the fourteen postoperative days this patient received 4,500,000 units of penicillin, 28.0 Gm. of streptomycin, and two blood transfusions. A follow-up chest plate on September 24 showed healing of the stump of the second rib, and there were no changes of the left apical area.

By November 3, there had been a 12 pound gain in weight, improvement in his cough, and an increase in hemoglobin to 12.8 Gm. He continued, however, to have a low grade fever and a persistent fistula in the left posterior scapular area. Multiple sinus tracts and excessive granulation tissue were excised surgically at this time. Microscopic examination of this tissue revealed granulation tissue containing several round to oval bodies having granular bluish staining centers with double refractile limiting membranes. It was thought at the time of the discharge of the patient that these represented blastomycosis.

In January 1949, this patient returned to the hospital with persistent drainage from the large sinus tract and a bluish nodule near the opening of this tract. The hemoglobin content was 11.6 Gm., the red blood cell count 4,300,000, the white blood cell count 9,500, and the sedimentation rate was 46 mm. in one hour. Direct examination of the material from the sinus tract showed large oval to round double refractile bodies with endospores, characteristic of Coccidioides immitis. A review of the microscopic sections taken in November 1948 revealed that the oval bodies previously described as Blastomyces dermatitidis were Coccidioides immitis. A section on the bluish nodule of the back showed granulation tissue containing large oval and thick walled bodies with endospores. Cultures on Sabouraud's medium (over which penicillin solution, 1,000 units per cubic centimeter had been flooded) with material taken directly from the sinus tract grew Coccidioides immitis. The chest plate at this time showed no new changes either in the chest or the ribs.

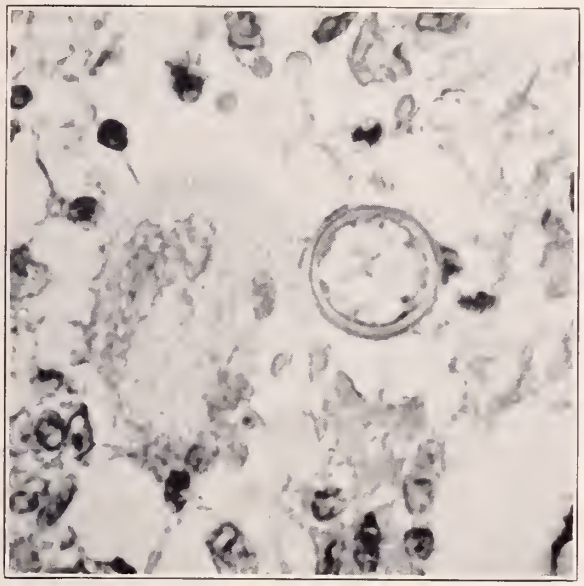

Fig. 1.—Photomicrograph showing round, thick-walled endospore-filled spherule characteristic of Coccidioides immitis.

Intradermal testing with our stock coccidiodin (1:100) was negative in November 1948 and January 1949. However, coccidioidin (1:1,000) supplied by Dr. C. E. Smith of Stanford University gave positive reactions. Serologic tests for coccidioidal infection with serum of this patient by Dr. C. E. Smith revealed a positive complement fixation test in a 1:32 dilution and a negative precipitin test. Doctor Smith reported that these findings were consistent with a severe coccidioidal infection in the range of dissemination. Intradermal skin test with the same coccidioidin on this man's wife of eight months was negative. At this time the patient was started and continued on "Diasone," 0.3 Gm., three to four times a day until a total of 76.5 Gm. had been given.

On Feb. 27, 1949 the patient complained of weakness in both legs. A lumbar puncture revealed clear and colorless spinal fluid under the initial pressure of 140 mm. of water. There was a prompt rise and fall to bilateral jugular compression. The spinal fluid protein was 450 mg. per hundred cubic centimeters. On March 5, 1949 the difficulty in walking had persisted and he was seen by Dr. Hans Reese, department of neurology, who noted that the leg movements were incoordinate and the muscle tone was decreased. The abdominal reflexes were hyporactive and the plantar reflexes were equivocal. There was a mild but definite hypesthesia from the second dorsal segment down. On March 15 another lumbar puncture was done and a complete subarachnoid block to jugular compression was found. On injection of 3.0 cc. of Pantopaque a complete block was found at the third dorsal vertebra. The spinal fluid proteins were 400 mg. per hundred cubic centimeters, and the culture was negative.

On March 15 an upper dorsal laminectomy was done by Dr. Harry Steelman, department of neurosurgery. On exposure the dura was found to be thin, and the extradural fat along with the whole cord was pushed posteriorly. No mass was encountered until the dura was resected medially; at this point a grayish, medium firm mass was encountered in the dorsolateral part of the spinal canal. It was about 1.0 cm. in diameter and about 3.0 cm. in length. The lesion had spread intraspinally through the nerve root canal between the second and third dorsal vertebra and had eroded the bone in this area. All of the diseased material was removed by curettement. The wound was irrigated with sulfadiazine and closure was made with interrupted wire sutures throughout.

Following surgical treatment, there was improvement with supportive care, including 500.0 cc. of blood, which was given because the hemoglobin had dropped to 9.6 Gm. and the red cell count to 3,500,000. On April 7, when he left the hospital against advice, the laminectomy wound was well healed and the draining sinus over the area of the left second rib was not.

Comments

This case of disseminated coccidioidomycosis acquired in California but symptomless until the patient became a resident of Wisconsin is another one to add to the mounting number of similar cases being found outside endemic areas. The vicariousness of the disease was well demonstrated by the cutaneous, osseous, pulmonary, neurologic manifestations in this patient. No marked response was seen to penicillin, streptomycin, or even 76.5 Gm. of "Diasone," which in a dosage of 38.5 Gm. had cured actinomycosis, another deep fungus, according to Arnold.[23] History of residence short or long in endemic areas should call for the following diagnostic procedures in any suspected case: (1) Intracutaneous tests with coccidioidin; (2) Culture and animal inoculation to demonstrate the fungus; (3) Biopsy studies of tissues; (4) Complement fixation and precipitin tests on the patient's serum for coccidioidomycosis; (5) Roentgenologic studies; and (6) Blood studies, including sedimentation rate.

Addendum

Two cases of coccidioidomycosis with only pulmonic involvement have been seen at Wisconsin General Hospital since this paper was prepared.

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MARQUETTE UNIVERSITY TO OFFER POSTGRADUATE COURSE IN HEMATOLOGY

A postgraduate course in hematology, sponsored by the Milwaukee Chapter of the American Academy of General Practice, will be conducted by the Marquette University School of Medicine at the medical school auditorium on March 4. Reservations may be made through the Dean's Office, Marquette University School of Medicine, 561 North Fifteenth Street, Milwaukee 3. There is a registration fee of $5.00.

The following lectures will be given:

a. m.

9:00–10:00 "The Functional Role of the Blood"—John S. Hirschboeck, M. D., dean, Marquette University School of Medicine

10:00–10:30 "Laboratory Aids in the Diagnosis of Blood Diseases"—John S. Hirschboeck, M. D., dean

10:30–11:30 "Therapeutic Conference: Anemia, Leukemia, Leukopenia, Purpura, and the Lymphomas"—F. W. Madison, M. D., associate clinical professor of medicine

a. m.

11:30–12:00 "Roentgen and Radioisotope Therapy of the Lymphomas and Blood Diseases"—Irving I. Cowan, M. D., assistant clinical professor of radiology

p. m.

2:00– 3:00 "The Proper Role of the Anticoagulants in Medicine"—Armand J. Quick, M. D., professor of biochemistry

3:00– 4:00 "The Practical Management of the Rh Problem"—Tibor J. Greenwalt, M. D., clinical instructor in medicine

4:00– 5:00 "Pernicious Anemia"—Steven O. Schwartz, M. D., Director of the Hematology Clinic, Cook County Hospital, Chicago

UNIVERSITY OF WISCONSIN OFFERS POSTGRADUATE COURSE IN GASTROENTEROLOGY

A course in gastroenterology will be presented at the University of Wisconsin Medical School, Madison, March 27–31, under the direction of Dr. Karver Puestow, of the department of internal medicine. The course is designed to cover the field from the standpoint of medical and surgical diseases, and emphasis will be placed on diagnosis, differential diagnosis, and recent therapeutic advances. The fee for the course is $25; there is no limit on the number of registrants.

Hotel reservations may be made by writing to the Hotel Loraine, Madison; it is requested that physicians mention their connection with this course when making reservations.

Pernicious Anemia of Pregnancy

By FRED J. HOFMEISTER, M. D., F. A. C. S., JAMES G. STOUFFER, M. D., and JOHN S. STEHLIN, M. D.

Milwaukee

F. J. HOFMEISTER

A graduate of Marquette University School of Medicine, Doctor Hofmeister maintains a private practice in obstetrics and gynecology and is also a clinical instructor in obstetrics and gynecology at Marquette. He is a diplomate of the American Board of Obstetrics and Gynecology.

J. G. STOUFFER

Doctor Stouffer, a 1946 graduate of the University of Wisconsin Medical School, interned at the Milwaukee Hospital. At present he is chief resident in obstetrics and gynecology at Milwaukee Hospital.

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A 1947 graduate of Marquette University School of Medicine, Doctor Stehlin interned at Milwaukee Hospital. Now serving a residency in general surgery at Milwaukee Hospital, he recently completed a residency in pathology at Baptist Hospital, Memphis, Tenn.

PERNICIOUS anemia of pregnancy has been known to occur for more than a century. It was first recognized by Channing[1] in 1842, who encountered 10 fatal cases of severe anemia associated with pregnancy. It was not until 1919, however, that Osler[2] described a severe anemia of pregnancy which he distinguished from Addisonian anemia by the frequency of recovery and absence of recurrence. Callender,[3] in her exhaustive review on the subject in 1944, stated that, although the total number of previous reports of cases is large (255), many of the earlier records are of limited value. She estimated that some of the previous reports may be accepted as probable cases of pernicious anemia of pregnancy, though in considerably less than half of the number was the diagnosis proved. This disease entity is considered to occur infrequently enough to warrant the following report of a case and discussion. Because of this infrequency and, consequently, the resultant inexperience with this anemia, fatalities are resulting which can be avoided by knowledge of this condition and early diagnosis. Pernicious anemia of pregnancy must be commonly suspected by all practitioners who treat obstetric conditions, since it simulates shock, sepsis, hemorrhage, nephritis, or toxemia.

It must be impressed that early and complete prenatal care will aid in alerting all practitioners for the possibility that the increasing anemia of their patient may need more than repeated routine hemoglobin examinations and iron therapy. Blood smears and bone marrow examination may reveal the diagnosis and point to the course of treatment necessary.

Report of a Case

This is the case of a 17 year old unmarried white girl who entered the Martha Washington Salvation Army Maternity Home on Dec. 27, 1947. She was a well developed, well nourished primigravida of approximately eight and one-half months gestation. Physical as well as obstetric examination was within normal limits. The red blood cell count was 3,200,000, and the hemoglobin content 10 Gm. per hundred cubic centimeters. Urinalysis was negative for sugar, albumin, and cells. An x-ray of the chest was within normal limits. She was placed empirically on ferrous glycinate, 500 mg. daily.

On Jan. 5, 1948, nine days after admission, she went into active labor. After eleven hours of labor she delivered via frank breech, a male infant with a large meningomyelocele with spina bifida and suggestive hydrocephalus. A left mediolateral episiotomy was done, and blood loss throughout delivery was minimal.

The mother had an uneventful convalescence until the eighteenth postpartum day. At this time, while walking to the dining room she suddenly collapsed. Physical examination shortly thereafter revealed an extremely pallid, listless, apathetic person, who appeared in a precomatose condition. Her temperature was 104.2 F. orally; respirations 26; pulse rate 116. The tongue was smooth and beefy red. A soft systolic murmur was heard at the apex. The ankles were slightly edematous. There was nothing in the physical examination to explain the high temperature and the immediate impression was that of sepsis.

Penicillin (50,000 units) was given intramuscularly every three hours. Blood was withdrawn for immediate study, and showed the red blood cell count to be 1,420,000, hemoglobin content 4.5 Gm. per hundred cubic centimeters, color index 1.4, hematocrit cell pack 15 mm., mean cell volume 107.1, and mean cell hemoglobin 32.1. Peripheral blood smear showed many macrocytes and a marked anisocytosis and poikilocytosis. No megaloblasts or nucleated red cells were seen. Five hundred cubic centimeters of whole blood was given. Further studies, including bone marrow and gastric aspirations, were done. Following histamine injection, free hydrochloric acid was found to be present, although in reduced quantities. The bone marrow report was as follows: The hematocrit reading showed myeloid 19.5 per cent, myeloid erythroid 3.5 per cent, plasma 76.5 per cent, and fat 0.5 per cent.

The differential cell count showed polymorphonuclears 0.5 per cent, stabs 8.0 per cent, juveniles 6.0 per cent, myelocytes 13.0 per cent, megaloblasts 45.5 per cent, eosinophilic normoblasts 14.5 per cent, eosinophiles 2.0 per cent, eosinophilic juveniles 0.5 per cent, and lymphocytes 7.0 per cent.

There had been marked hyperplasia of the bone marrow, as evidenced by the hematocrit readings. This hyperplasia was due to an increase in the number of red blood cells. The erythropoietic tissue showed a well marked maturation arrest.

Following this report, a tentative diagnosis of pernicious anemia of pregnancy was made. Liver therapy in the form of Lederle's crude liver extract with folic acid was begun (4 units U.S.P. liver; 4 mg. of folic acid daily). Within four days the patient became afebrile, and there was evidence of a marked response, both clinically and hematologically. Following twenty-four days of parenteral liver and folic acid therapy, all medication was discontinued and the patient was discharged.

She has since been followed at frequent intervals and her condition continues to remain good. Subsequent negative stool examinations and normal gastrointestinal x-ray studies have further confirmed the diagnosis of pernicious anemia of pregnancy. It may be said that the infant at six months has developed a marked hydrocephalus and at no time has shown signs of anemia. Six months following discharge, the mother's red blood cell count was 4,500,000, with 13 Gm. per hundred cubic centimeters of hemoglobin.

Discussion

The etiology of pernicious anemia of pregnancy has been ascribed to many theories—nutritional deficiency, intrinsic factor deficiency, endocrine influences, and hemolysis. No attempt was made in this case to establish a definite causative factor; however, it is interesting to note the marked reticulocyte response following parenteral administration of liver and folic acid therapy. This would tend to support the theory of Strauss and Castle[4] of absence of an extrinsic factor.

The following table shows how this case compares to the more frequent findings in pernicious anemia of pregnancy as described by Callendar[3], Wintrobe[5] Elliott[6], and Whitby and Britton[7].

The diagnosis is frequently overlooked, according to Wintrobe[5]. The mistaken diagnosis of sepsis is made because of the associated pyrexia, or the presence of edema and albuminuria may suggest chronic nephritis or toxemia. There are not clinical features which point unequivocally to the diagnosis. The diagnosis rests on complete hematologic investigation

Findings in Pernicious Anemia of Pregnancy

Frequent Findings	This Case
1. Usually under 35 years of age	1. 17 years of age
2. More often multiparas.	2. Primipara
3. Onset of symptoms sudden, usually during third trimester or puerperium	3. Onset of symptoms sudden on 18th day postpartum
4. Vomiting and diarrhea in 40 to 50 per cent	4. None
5. Atrophy of papillae and glossitis	5. Present
6. Slight edema	6. Present
7. Splenomegaly in 30 per cent	7. Absent
8. Pyrexia common, sepsis infrequent	8. Present
9. Achlorhydria and cord changes seldom	9. Free acid present in stomach. No cord changes
10. Macrocytosis in peripheral blood with anisocytosis and poikilocytosis	10. Present
11. Color index and mean corpuscular volume high	11. Present
12. Hyperplastic megaloblastic bone marrow	12. Present
13. Diagnosis usually not made until hemoglobin is below 30 per cent	13. Diagnosis made when hemoglobin was 29 per cent

demonstrating a hyperchromic macrocytic anemia with a hyperplastic megaloblastic change in the bone marrow. True pernicious anemia was ruled out by the presence of gastric hydrochloric acid, and the absence of relapse for six months following discontinuance of liver and folic acid therapy, even though this may be a relatively short period of time. Nutritional macrocytic anemia was eliminated by the history of an adequate diet, negative stool examinations for ova and parasites, and negative gastrointestinal x-ray studies. It is noteworthy that the patient showed a marked reticulocyte response with as little as 4 units of crude liver extract and 4 mg. of folic acid daily. Whole blood was given to obtain a safe blood level until the liver and folic acid took effect. Penicillin was administered because sepsis was our first consideration until hematologic study provided our proper diagnosis. The value of vitamin B12 in treatment of pernicious anemia of pregnancy has not yet been established, but preliminary reports indicate that its value is questionable.

This case bears out the dictum that any hemoglobin determination below 10 Gm. per hundred cubic centimeters during pregnancy should be considered pathologic and warrants complete hematologic investigation.

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Bacterial Endocarditis

A Review of 70 Cases Over a Ten Year Period

By WILLIAM M. FITZGERALD, M. D.
Beloit

W. M. FITZGERALD

A native of Beloit, Doctor Fitzgerald is now an internist at the Beloit Clinic in that city. He received his M.D. degree from Northwestern University Medical School, interning at St. Louis City Hospital. He remained there for a residency in internal medicine, following which he served as a medical officer in the United States Navy.

PRIOR to the advent of the present day use of the antibiotics, bacterial endocarditis was almost a 100 per cent fatal disease. However, since penicillin and, later, streptomycin have now become more available to the public, there have appeared many recent reports in the literature relative to this subject and the results obtained from their use in the treatment of this disease. It has been said that once a cure for a particular disease becomes known, research into that disease almost automatically ceases, but in the case of bacterial endocarditis rather the reverse seems to be true. Reports are now available which include follow-ups for as long as two years following treatment with penicillin.

It was deemed desirable to undertake this review with the hope that it might serve as an aid to more accurate and earlier diagnosis, for, as it has recently been pointed out by Fiese,[2] although the infective process can be controlled by the proper use of the antibiotics, some patients ultimately go on to cardiac failure and death as a result of the structural changes which occur in the cardiac valves during this disease.

Although the difference is not always distinct and there is overlapping, enough difference exists in spite of the now prevalent use of the antibiotics to distinguish between acute and subacute forms of bacterial endocarditis. This review includes 23 cases of the acute form, and the remaining cases are of the subacute variety.

The criteria for the selection of these cases included the clinical diagnosis of bacterial endocarditis, the finding of a positive blood culture, and/or the establishment of this diagnosis at autopsy. Autopsies were performed in 65.7 per cent of the cases, and one or more positive blood cultures were present in 86.2 per cent of the cases in which blood cultures were performed.

Age and Sex

The youngest patient was 11 years old and the oldest patient was 85 years of age. The average age was 42.2 years, and in this series the greatest incidence of the disease occurs between the ages of 20 and 59, with the highest incidence per decade appearing between 20 and 29.

There were 37 (52.8 per cent) males and 33 (47.2 per cent) females.

Seasonal Incidence

Figure 1 gives the incidence of the disease according to months in the year. It can be seen that the highest peak occurs during the months most commonly associated with the highest rate of upper respiratory infections, which is later borne out in this series by the finding of upper respiratory infections as the most common preceding disease.

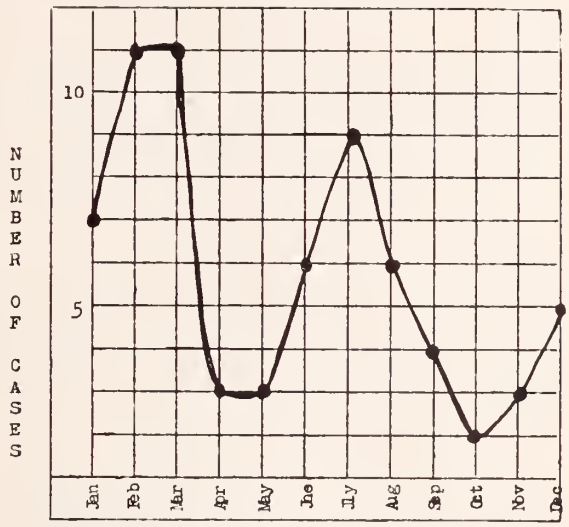

Fig. 1.—Commonest months of occurrence.

Previous Rheumatic History

Only nineteen (27 per cent) of the patients gave a history of previous rheumatic fever. Four (5.7 per cent) gave a history of scarlet fever, and 2 (2.8 per cent) were known to have had chorea previously. One patient (1.4 per cent) gave a history of frequent attacks of sore throat. One (1.4 per cent) case was that of congenital heart disease, which at autopsy was shown to consist of a patent foramen ovale and an intraventricular septum defect. From the foregoing it can be seen that 37.1 per cent of the 70 cases studied gave histories of one or more of the infections commonly listed in the so-called rheumatic triad.

Sources of Infection

Table 1 lists the probable sources of infection. In 46 (65.7 per cent) cases none could be elicited. A preceding upper respiratory infection, including all of the usual known varieties, was the most commonly encountered preceding infection, and this occurred in 22.8 per cent of the cases. In this series only 4 cases (5.7 per cent) gave a history of previous recent dental extractions. The remainder of the possible sources of infections included pneumonia, empyema, criminal abortion, neisserian urethritis, and diabetes mellitus. Cases in which a preceding surgical procedure had been performed accounted for 5 (7.1 per cent) of the cases.

TABLE 1.—*Sources of Infection*

Source of Infection	No. of Cases	%
Unknown	46	65.7
Upper respiratory infection preceding	16	22.8
Previous operations (within 4 months)	5	7.1
Dental extractions	4	5.7
Pneumonia	4	5.7
Gonococcic urethritis	2	2.8
Diabetes mellitus	2	2.8
Criminal abortion	1	1.4
Empyema	1	1.4

Length of Disease

The average length of the disease from the appearance of first symptoms to the date of death or discharge from the hospital in the acute cases was twenty-two and three-tenths days and in the subacute cases ninety-seven and two-tenths days.

Symptomatology

The most prominent symptom in this series of cases was fever, which occurred in every case, and second in order of frequency was dyspnea. Following these (table 2) came anorexia, chest pain, and weight loss, which appeared in this order of frequency.

TABLE 2.—*Symptomatology*

Symptom	No. of Cases	%
Fever	70	100
Dyspnea	51	72
Anorexia	40	57
Chest pain	28	40
Weight loss	28	40

Physical Findings

Eighty-four per cent of the patients had significant cardiac murmurs on admission to the hospital. It has been said by some investigators that bacterial endocarditis does not occur except upon previously damaged heart valves or upon congenitally diseased endocardium. However, in this series this pre-existing damage was not manifested by murmurs in 16 per cent of the cases. The most common murmur heard was the mitral systolic, and all types of combinations of systolic and diastolic murmurs were heard at the mitral, aortic, and tricuspid valves.

Table 3 lists the most common physical findings in the order of their frequency. Tachycardia was found in 85 per cent of the cases, and this was followed by clinical cardiac enlargement, which occurred in 60 per cent. Petechiae, which is the finding frequently considered to be most suggestive of bacterial endocarditis, was present in only 57 per cent. Auricular fibrillation has long been considered to be an uncommon finding in bacterial endocarditis.

TABLE 3.—*Physical Findings on Admission*

Physical Findings	No. of Cases	%
Tachycardia	60	85
Clinical cardiac enlargement	42	60
Petechiae	40	57
Signs of cardiac failure	36	51
Palpable liver	30	42
Palpable spleen	21	30
Clubbed fingers	15	21
Osler's nodes	10	14
Splinter hemorrhages	5	7

More recently, according to McDonald,[3] it is considered to be a finding which occurs in old and damaged hearts regardless of the type of infection, and because bacterial endocarditis most frequently occurs in the young, it is, therefore, so seldom seen. It was found in 6.8 per cent in this group, all of which were proved by the electrocardiograph. Five patients (7.1 per cent) showed blood pressure recordings compatible with the diagnosis of hypertension, and the average blood pressure recording in the entire series of cases was 119 systolic and 60 diastolic. These normal blood pressures may well be interpreted in the light of the fact again that this is a disease of the younger age group.

Laboratory Data

The average erythrocyte count (table 4) was found to be 3.9 and the average hemoglobin determination was 69 per cent of normal, which figures are in keeping with the mild degrees of anemia occurring in this disease. Contrary to the findings of Seabury[4] in whose series of 165 cases, 53.4 per cent had a white blood cell count between 5,001 and 10,000, the average white blood cell count in this

TABLE 4.—*Laboratory Data*

Physical Findings	No. of Cases	%
Leukocytes in urine	49	70
Leukocytosis	45	64
Arneth count (shift to the left)	35	50
Anemia	41	58
Microscopic hematuria	37	52
Albumin—trace—4 plus	26	37
Elevated nonprotein nitrogen level	16	22
Casts in urine	13	18
Positive Wassermann reaction	9	12
Glycosuria	6	8

group was 13,646. Microscopic hematuria was found in over half of the cases, and albuminuria was an occurrence in approximately one-third.

Bacteriologic Data

An attempt to correlate the types of organisms found in both the heart and the blood cultures was made and the results are given in table 5. A large variety of organisms was present, and, as is to be expected, the Streptococcus viridans was found in both the heart and the blood cultures in the highest percentage of cases. This was followed in frequency by the nonhemolytic streptococcus. The remainder of the organisms which were cultured from both sources included Staphylococcus albus and Staphylococcus aureus, pneumococcus, hemolytic streptococcus, Neisseria gonorrhoeae, diphtherioids, Bacillus mallei, Bacillus proteus, and Escherichia coli. Many of these organisms were found in combination, which raises the question of mixed types of infection, which possibility should not be overlooked in the approach to successful treatment of this disease. According to Kerr[5] it has been observed that the elimination of one organism by the use of an antibiotic may permit the growth of another. In this series no single combination of organisms appeared both in the blood stream and in the postmortem heart cultures.

TABLE 5.—*Bacteriologic Data*

Types of Organisms	Heart Culture,		Blood Culture,	
	No. of Cases	%	No. of Cases	%
Not cultured	43	61.0	12	17.1
Positive blood cultures	23	85.1	50	86.2
Negative blood cultures	4	14.9	8	13.8
Str. viridans	8	34.7	26	52.0
Nonhemolytic streptococcus	5	21.7	10	20.0
Staph. albus	4	17.5	9	18.0
Staph. aureus	7	30.4	5	10.0
Pneumococcus	2	8.7	5	10.0
Hemolytic streptococcus	4	17.5	4	8.0
Gonococcus	1	4.3	2	4.0
Diphtheroids	2	8.7	2	4.0
Bacillus mallei	5	21.7	1	2.0
Escherichia coli	2	8.7	1	2.0

Radiographic and Electrocardiographic Findings

The most common radiographic finding in the chest plates on this series of cases was that of cardiac enlargement in one or more of the cardiac diameters. The x-ray revealed 7 cases of pneumonia, whereas the pneumococcus was obtained from the blood in culture in only 5 cases. The electrocardiograph illustrates many variations from the normal, including evidence of myocardial damage as shown by changes in the T-waves, which occurred in 38.5 per cent of the cases; abnormal axis deviation, right and left; auriculoventricular and intraventricular heart block; extrasystoles; bundle branch block; and auricular fibrillation. Table 6 shows the relative percentages of these electrocardiographic findings, from which it can be seen that, although there is no typical pattern pathognomonic of bacterial endocarditis, a large percentage of the patients will show evidence of disease of both the myocardium and/or the conduction system.

TABLE 6.—*Radiographic and Electrocardiographic Findings*

	No. of Cases	%
Chest plates not taken	18	25.7
Chest plates taken	52	74.3
Cardiac enlargement	26	50.0
Pneumonia	7	13.4
Electrocardiographs not taken	26	37.1
Electrocardiographs taken	44	62.9
Normal electrocardiograph	3	6.8
Myocardial pathology	27	61.3
Left axis deviation	11	25.0
Auricular ventricular conduction defect	9	20.4
Ventricular extrasystole	8	18.1
Sinus tachycardia	5	11.1
Right axis deviation	5	11.1
Intraventricular conduction defect	4	8.9
Supraventricular extrasystole	4	8.9
Left ventricular preponderance	4	8.9
Auricular fibrillation	3	6.8
Right bundle branch block	1	2.2

Necropsy Data

Of the cases reviewed, 65.7 per cent came to autopsy, and of this number the most common abnormal finding was that of cardiomegaly, which was noted in 67.4 per cent. Mitral valve vegetations were found in 58.7 per cent of the cases, although mitral stenosis was found in only 34.8 per cent. White, in his text on "Heart Disease," states that markedly stenosed valves are less frequently attacked by this disease than the less deformed valves and that those on the left side of the heart are those most frequently involved. This is borne out in the findings appearing in table 7. In this series of cases, no one valve escaped involvement. The remainder of the autopsy findings with the exception of pericarditis, which occurred in 21.7 per cent, and nephritis in 28.2 per cent, are attributable to embolic phenomena and include infarction of the spleen, kidney, lung, and brain.

TABLE 7.—*Autopsy Findings*

Autopsy Data	No. of Cases	%
Autopsies performed	46	65.7
Cardiomegaly	31	67.3
Mitral valve vegetation	27	58.7
Spleen infarct	25	54.3
Aortic valve vegetation	24	52.1
Kidney infarct	19	41.3
Mitral stenosis	16	34.8
Aortic and mitral valve vegetation	14	30.4
Nephritis	13	28.2
Pericarditis	10	21.7
Aortic stenosis	8	17.4
Lung infarct	8	17.4
Tricuspid valve vegetation	7	15.2
Aortic and tricuspid valve vegetation	3	6.5
Pulmonary valve vegetation	2	4.3
Aortic, mitral, tricuspid valve vegetation	1	2.1

Therapy

This series of cases includes the decade of 1938 to 1947 and was so chosen because during this period the rationale of therapy of this disease underwent three more or less distinctive changes, viz., the

symptomatic, which included the use of tranfusions with whole blood which presumably contained the antibodies resultant from previous infection by the Str. viridans, the use of the sulfonamides alone or in conjunction with various types of fever therapy, and most recently the use of penicillin. Prior to the use of penicillin, which appeared in this series for the first time in 1946, no patient lived to be discharged from the hospital, although in several cases it appears that the course of the disease may have been lengthened by the use of the sulfonamides.

There was a total of 9 patients treated with penicillin, all of which was given via the intermittent intramuscular route. One patient received a total dose of only 580,000 units because at that time penicillin was available in only very limited quantities, and this small dosage succeeded in neither sterilizing the blood stream nor affecting the course of his disease, and he expired after two weeks in the hospital. Because there was available no means of evaluation of dosage or length of treatment, there was a wide range of total dosage used, which varied from 280,000 units to 25,000,000 units in the 9 patients so treated. No tests for penicillin sensitivity of the isolated organisms were done. In each case the blood stream became sterile and had remained so for a period of two weeks or three negative blood cultures before antibiotic therapy was discontinued. One case, that of a 29 year old woman with a history of rheumatic fever, in whom bacterial endocarditis subsequently developed and who was successfully treated with penicillin, was given additional penicillin treatment approximately two months later, at the time of several dental extractions. The average individual dose in this series was 30,000 units given every three hours via the intramuscular route. Of the 9 patients treated with penicillin, 2 died, for a mortality rate of 22.2 per cent. Both of the cases can be considered therapeutic failures, for in neither case were sterile cultures demonstrated before death, and both patients died within a period of two weeks following the beginning of therapy.

Follow-Up

All of the 7 patients who were discharged as cured were followed in the outpatient department for periods of six to twelve months, during which time sedimentation rates, blood cultures, and temperature recordings were made. It was noted in 3 cases that, in spite of elevated sedimentation rates, and the occasional appearance of some petechiae and occasional low grade fever, the blood stream remained sterile and no other clinical manifestations of continued infection became apparent. In 1 patient the sudden onset of a right hemiparesis developed, presumably due to a cerebral embolus ten months following his discharge from the hospital as cured. Blood cultures made both prior to and subsequent to this accident had been continuously sterile, and there did not develop any signs of recurrent endocarditis. Another patient, who was followed for a period of twelve months, complained of night sweats, during which time there was no positive laboratory evidence of bacteremia. All 7 patients followed were able to return to comparatively normal activity, which was limited only by the extent of their pre-existing heart disease.

Summary and Conclusions

Seventy cases of bacterial endocarditis have been reviewed with regard to the clinical, bacteriologic, and pathologic features of the disease and the results of treatment with transfusions, sulfonamides, and penicillin.

Bacterial endocarditis occurs in all ages, with the highest incidence in the third decade.

There is a direct correlation between the incidence of this disease and that of upper respiratory infection.

The mitral systolic murmur is the most commonly encountered cardiac murmur and in some cases there may be no murmurs early in the disease.

Tachycardia is a very frequent finding, as are mild degrees of anemia, mild degrees of leukocytosis, and hematuria.

The absence of a positive blood culture does not rule out the disease, and the repeated use of this test is desirable.

The pathology of the disease and subsequent cardiac damage resultant therefrom demand the earliest possible diagnosis and vigorous treatment.

No recoveries occurred in the patients treated by means other than the antibiotics.

Of the 9 patients treated with penicillin, 7 have probably been cured, for a mortality rate of 22.2 per cent.

The use of large doses of penicillin via the intermittent intramuscular route will result in the cure of some of the patients with this disease.

Patients in whom the blood stream is sterilized should be followed up with subsequent blood cultures.

The continued existence of elevated sedimentation rate, low grade fever, and/or the subsequent appearance of some petechiae do not necessarily imply a recurrence of a bacterial endocarditis.

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Management of Acute Injuries of the Head*

By H. J. SVIEN, M. D.
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H. J. SVIEN

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THE purpose of this paper is to present a definitive plan for the management of injuries of the head. No attempt will be made to discuss the pros and cons of the various controversial issues, such as the use of dehydrating solutions, the proper place of spinal puncture, and so forth. Each procedure will be mentioned and its use discussed where the author has found it to be of merit.

The general precepts of adequate care of the patient with an acute injury of the head may be divided into the following categories: (1) attention to the respiratory state, (2) treatment of shock, (3) meticulous examination and observation with a view to early recognition of surgical emergencies, (4) good nursing care, (5) maintenance of a state of rest, (6) control of body temperature, (7) maintenance of fluid balance and nutrition, (8) control of intracranial pressure, and (9) early exploratory trephination in selected cases.

The establishment and maintenance of an adequate airway takes precedence over all other measures in caring for the unconscious patient. The tendency for the tongue to drop back into the throat can often be prevented by simply placing the patient on his side. If this maneuver is not adequate, a small airway may be introduced. Accumulations of saliva, mucus, blood, and vomitus should be aspirated from the airway with a small rubber catheter and aspirator as frequently as their collection warrants. This procedure not only assists in maintaining an adequate airway but may prevent aspiration of the fluid and subsequent pneumonia. Elevation of the foot of the bed promotes dependent drainage of the fluid in the tracheobronchial tree and is helpful in keeping the respiratory passages free of accumulations of fluids. In the presence of fractured jaws or trauma leading to swelling and edema of the pharynx and buccal cavity, tracheotomy should be seriously considered and carried out if there is question of being able to maintain a free respiratory passage without this means. If evidence of respiratory embarrassment or involvement of the respiratory center is present, as evinced by cyanosis, Cheyne–Stokes respiration, or an excessively rapid or excessively slow respiratory rate, oxygen therapy is necessary. An oxygen tent in this instance is ineffective because sufficient concentration of oxygen cannot be reached to meet the needs of such patients. A face mask is preferred. A mixture of oxygen (95 per cent) and carbon dioxide (5 per cent) is preferable to pure oxygen. The inhalation of pure oxygen results in mild vasoconstriction, while the addition of carbon dioxide to the inhaled gas improves the cerebral flow of blood[1]. A flow of 6 to 8 liters per minute has proved to be the optimal rate. Oxygen therapy is beneficial in these cases inasmuch as the congestion and edema of the brain inhibit the delivery of oxygen to this tissue and leads to further edema and increased anoxemia, thus initiating a vicious cycle. Oxygen therapy may thus assist in preventing the onset of increased intracranial pressure.

A state of shock is rarely encountered by the physician in patients with uncomplicated injuries of the head. When the condition of shock is present, a careful search for associated injuries, such as perforated viscus, ruptured spleen or liver, thoracic injury, or severe skeletal fractures, should be made. In an occasional case, a laceration of the scalp, which has an unusually rich blood supply, may bleed sufficiently to produce shock; appropriate bandaging of the head will serve temporarily to meet this contingency. Primary, or neurogenic shock, which is generally short lived, undoubtedly occurs at the time of the injury to the head, but by the time the patient is first seen by the physician, it has generally disappeared. If shock is present the standard methods of treatment are employed. Some of the newer blood substitutes, such as dextran, have proved to be efficacious.

While the above-mentioned procedures are being carried out, an accurate history can be taken from whatever witnesses are available. The nature and force of the blow to the head should be considered. The length of the time interval between injury and examination should be determined. The presence of a lucid interval and its duration should be noted. When all the available facts have been obtained, a careful physical and neurologic examination is carried out. The general physical examination should determine the presence or absence of associated injuries. The patient should be catheterized to rule out the presence of bleeding from the urinary tract. The extent and nature of lacerations or abrasions of

* Read before the meeting of the Chippewa Falls County Medical Society, May 24, 1949.

the scalp should be evaluated. The presence or absence of otorrhea or rhinorrhea should be noted. The blood pressure, pulse rate, and respiratory rate should be recorded.

It is important that the neurologic survey give an adequate base-line evaluation of the patient's condition. The state of the pupils should be noted; equality, reaction to light, and conjugate deviation, if present, should be recorded, as should be the presence of palsies of the ocular muscles. The presence of hemiparesis may be difficult to determine in the unconscious patient. Observation of the patient's breathing may be of help. If hemiparesis is present, the ala nasi on the paralytic side does not flare with inspiration as does the ala on the normal side. Observation of the spontaneous movements of the patient will also give some clue as to which is the weak side. Both eyelids should be raised passively. The normal eyelid promptly falls back into the closed position and completely covers the eye; the eyelid on the affected side slowly falls back into its normal position. When the arm of the normal side is raised above the face and thorax and then released, its normal tone guides it back into its position by the side of the body without falling on the face or thorax. When this maneuver is carried out with the weak side, the arm drops limply onto the face or thorax. On passive flexion of the lower extremity followed by sudden release, on the normal side, the limb rather slowly assumes its usual position; after this maneuver on the affected side the leg falls quickly into an abducted and extended position. The deep tendon reflexes, the abdominal reflexes, and the Babinski sign should be elicited and compared on the two sides. Roentgenograms of the skull should then be taken. These should consist of anteroposterior, posteroanterior, and lateral views. Roentgenograms of the cervical portion of the spinal column should be taken when indicated by the history or physical findings. A roentgenogram of the thorax should be included routinely in this early roentgenologic survey. Roentgen examinations of this nature, if the patient is carefully handled, can be done without hazard to the patient. Adequate roentgenologic examination at this point is important, not only from the standpoint of adequate evalution of the patient's condition, but also from the medicolegal aspect.

When the examination of the patient has progressed to this point, it is necessary to decide whether or not early surgical intervention is indicated. From 10 to 15 per cent of patients with head injury seen in the usual practice require early surgical treatment. The conditions necessitating early surgical intervention are (1) certain depressed fractures of the skull, (2) compound fractures of the skull, (3) craniocerebral wounds, and (4) epidural hemorrhage.

A depressed fracture of the skull may consist of depression of the internal table alone or of both tables, in either instance with or without penetration of the dura and with or without local extradural extravasations of blood or contusion and bleeding of the underlying brain. Although roentgenographic examination is helpful, the diagnosis of the extent of the injury cannot be determined with certainty by this means. If the patient is conscious and if the depression overlies one of the so-called silent areas of the brain and does not involve the venous sinuses, and if the scalp is not penetrated, one can justifiably delay elevation of the depressed bone. However, if the patient is unconscious the depressed bone must be elevated and the site of fracture investigated as a possible source of intracranial bleeding. If the depressed part overlies the motor strip or a large vascular channel, early elevation is indicated. If the scalp is lacerated over a depressed fracture, a compound injury exists, a condition which requires early correction. In some cases of depressed fracture of the skull, it is advisable to sacrifice the comminuted fragments and to cover the bony defect with a tantalum plate. In many cases this procedure can be carried out along with the initial operation, thereby obviating the necessity of a secondary procedure.

Compound fractures of the skull require correction as early as possible. The fracture line should be examined carefully for imprisoned foreign particles. If these are present, it may be necessary to enlarge the fracture line in order to remove them. The underlying dura should be examined, and if lacerated, should be properly repaired. Damaged brain tissue, if present, should be adequately removed.

Craniocerebral wounds demand early surgical care. As in most of the cases discussed above, these cases represent major neurosurgical procedures which should be carried out in hospitals especially equipped for neurosurgical work. When these facilities are not immediately available, the craniocerebral wound should be irrigated gently with penicillin solution and lightly packed with moistened gauze strips, after which a fairly snug head dressing should be applied. The scalp should be shaved for a generous area surrounding the wound, and the bleeding vessels in the scalp tied off as preliminary steps. The patient should then be transported to the nearest adequate facility.

Epidural hemorrhage should be recognized as early as possible. A history of a lucid interval, progressive contralateral hemiplegia and coma, ipsilateral dilated pupil, and a fracture across the course of the middle meningeal vessels constitutes the classic chain of events and findings. The lucid interval may vary from one to twenty-four hours or more, depending on whether the main trunk of the middle meningeal artery, its smaller branches, or the accompanying veins are the source of bleeding. In a severely injured patient the lucid interval may be absent. In these cases a deepening of the unconscious state is seen and repeated neurologic examination will reveal a progressive hemiplegia. Hemiplegia which comes on immediately after trauma is due generally to cerebral laceration and is generally not amenable to surgical treatment. Coincidentally with the progression of the hemiplegia, a deepening coma

develops. If the lucid interval is short, coma is generally rapid in its development and is complete in two or three hours. Dilatation of the ipsilateral pupil will be present in about half of these cases.[2] Fracture across the course of the middle meningeal vessels is present in about 85 per cent of cases of epidural hematoma.[3]

The treatment of epidural hemorrhage consists of placing a burr hole over the course of the middle meningeal vessels in the temporal region halfway between the zygoma and the parietal boss in a line extending vertically from the tragus. If a hematoma is present it is evacuated. In order to find the bleeding point of the vessel involved, it may be necessary to do a subtemporal decompression, and at times it may be necessary to ligate the vessel at its entrance into the skull (foramen spinosum). This procedure can best be carried out in a hospital equipped for neurosurgical operations. However, if the coma, hemiplegia and other signs of extradural hemorrhage develop so rapidly that doubt exists as to whether the patient can be transported to such a hospital in time, the attending physician, or the general surgeon in the area, should place the burr hole as described. The hematoma should be evacuated. If the bleeding point cannot be easily found, a Penrose drain should be inserted over the involved dura and the wound lightly closed. The patient should then be given supportive treatment consisting of a blood transfusion if necessary, and transported to a neurosurgical facility.

If the patient under consideration does not fall into one of the above-mentioned categories in which early surgical intervention is required, conservative measures are employed. Good nursing care is an essential feature of this program. Graphic records should be kept of the blood pressure, pulse rate, and respiratory rate. These observations should be recorded as frequently as every half hour during the critical phase. A statement as to the level of consciousness should also be recorded. In this way, subtle changes in the condition of the patient will be recognized early. The patient should be placed in the semi-Fowler position as soon as his condition will permit. This position provides dependent drainage of the injured brain and may be effective in lessening the degree of impending cerebral edema. A record should be kept of the patient's intake and output of fluid. These data are important in planning subsequent administration of fluids. If the patient is incontinent, an indwelling catheter should be used. This expediency not only permits of accurate measurement of urinary output, but also obviates the irritation of the skin which results from lying in a wet bed. The eyes should be irrigated at least twice daily with a saturated solution of boric acid, and sterile mineral oil should be instilled into the conjunctival sacs twice daily. These procedures prevent corneal irritation in the patient who is unconscious and whose corneal reflex is absent. Drying and cracking of the lips and tongue can be prevented by applying glycerine to these structures several times daily. Parotitis can be prevented by coating the inside of the buccal membranes with lemon juices several times a day.

The extreme restlessness of many of these patients is definitely detrimental to their well-being and progress. Such activity increases their oxygen demand, utilizes their store of energy needlessly, and subjects them to the danger of additional trauma. In many instances this restless state is initiated and maintained by the presence of a full bladder, and the passing of a catheter solves the problem. Sedation may be necessary in some cases. Morphine should not be used. This drug depresses an already disturbed respiratory center, masks the pupillary changes, and clouds the true state of consciousness. Either chloral hydrate in a dose of 20 to 40 grains (1.3 to 2.6 Gm.) by rectum or paraldehyde in the same amount should be tried first, inasmuch as these drugs are not respiratory depressants and can be employed with relative safety. If the patient can swallow without difficulty or if a stomach tube is in place, they can be given by mouth in somewhat smaller doses. If either of these drugs does not produce the necessary degree of quietude, the physician can then resort to sodium phenobarbital subcutaneously in doses varying from 2 to 4 grains (0.13 to 0.26 Gm.). In the occasional patient it may be advisable to use sodium amytal (sodium isoamylethylbarbiturate) intravenously, in doses ranging from 3¾ to 6 grains (0.25 to 0.4 Gm.). If restlessness persists despite the use of these measures spinal puncture on the second, third, or fourth day after injury may be advisable. Removal of the decomposition products of blood, which are irritating, from the subarachnoid spaces often helps considerably in quieting such a patient.

Extreme degrees of fever in a patient with an injury to the head are detrimental. The demands for energy and oxygen are increased and the processes of cell destruction are augmented. Attempts should be made to keep the temperature below 102 F. Probably the most effective method is to employ alcohol sponge baths frequently. The alcohol is cooled by introducing ice cubes into the solution. An electric fan which is placed near the bedside is then directed over the exposed body. This method can be supplemented by the use of ice water enemas and aspirin in doses of 10 to 20 grains (0.65 to 1.3 Gm.) by rectum.

Maintenance of fluid balance and nutrition in the patient who remains unconscious for a number of days is extremely important. With the scepter of cerebral edema ever present in these cases it is advisable to keep the patient slightly dehydrated from the beginning. During the first twenty-four hours the patient is given 1,000 to 1,500 cc. of 5 per cent solution of glucose in distilled water by the subcutaneous route. This mode of administration assures a slow uptake and utilization of fluid and prevents flooding of the tissues which have been damaged and whose function of fluid interchange is presumably already disturbed. The administration of fluid during the second twenty-four hour period is determined by the urinary output of the first

twenty-four hours. An output of 500 to 600 cc. is desirable. Generally from 1,200 to 2,000 cc. are required, depending on the temperature of the room, the rate of respiration, and so forth, during the second twenty-four hour period. Five hundred cubic centimeters of this amount should be in the form of physiologic saline solution; this amount provides about 4 Gm. of salt. If renal function is adequate this quantity of salt will be sufficient to prevent depletion of electrolytes. If the patient is still unconscious and unable to swallow on the third day, a Levin stomach tube is inserted. During the first six to eight hours, 1 ounce (about 30 cc.) of water is given each hour in order to accustom the inactive gastrointestinal tract to the ingestion of food. After this period, use of a standard formula, designed for feeding by stomach tube, is instituted. This formula, made up of egg yolk, evaporated milk, skimmed milk, and vitamin supplements, has an energy content of 1 calorie per cubic centimeter. From 1,500 to 2,000 cc. per twenty-four hours are administered. This quantity provides about 100 Gm. of protein and 4 Gm. of salt.

Although edema of the injured brain undoubtedly begins to develop shortly after injury, its manifestations in the form of increased intracranial pressure do not reach their maximum until thirty-six to seventy-two hours after trauma. The usual signs resulting from increased intracranial pressure are lowered pulse rate, increased or irregular respirations, and often deepening coma. Funduscopic examination may reveal evidence of early choking of the disks. If these signs are present early after injury, intracranial hemorrhage is the probable cause. It has already been stated that the patient is kept slightly dehydrated during the first three days after his injury as a prophylaxis against cerebral edema. If this condition develops in spite of prophylactic measures, definite dehydration procedures are instituted. The simplest and least expensive measure, and one which is effective, is the use of phospho-soda (Fleet) in a dose of 3 to 5 drams or magnesium sulfate by mouth or, if the patient cannot swallow, by stomach tube. An enema of magnesium sulfate is likewise quite effective. If more rapid dehydration is indicated, 80 cc. of serum albumin is employed intravenously every three to six hours as needed. Although this substance is eminently effective it has the disadvantage of being expensive. A less effective intravenous method, but one that is not so costly, is the administration of 50 per cent solution of sucrose in 75 cc. doses at six hour intervals. This substance should not be used more than three times successively, because it is an irritant to the renal glomeruli and tubules. If the above-mentioned measures do not produce acceptable results, spinal puncture and drainage should be considered. Manometric studies are carried out, and the pressure is reduced a third to a half. Thus, if the initial pressure exceeds 60, expressed in centimeters of spinal fluid, the pressure is reduced a third; if the initial pressure is below 60 cm., it is reduced a half. Jugular compression should not be carried out. In the first place, this procedure contributes no usable information, and in the second place it is potentially dangerous in that it increases an already excessive intracranial pressure. There is some risk of producing cerebellar herniation by spinal drainage in this situation, and therefore this procedure should not be employed routinely and injudiciously. It is best employed early in the development of increased intracranial pressure.

When dehydration measures have been employed more than twenty-four hours, the physician may well wonder as to the state of hydration and electrolyte balance of his patient. Determinations of blood chlorides and carbon dioxide-combining power should be made at this time. If the value for blood chlorides is reduced from the normal of 580 mg. per hundred cubic centimeters, physiologic saline solution should be administered. As a rule of thumb, 0.5 Gm. of sodium chloride per kilogram of body weight should be administered for every 100 mg. the level of blood chlorides is below normal. Thus, if in a patient weighing 60 kilograms, the value for blood chlorides is 530 mg., 15 Gm. of sodium chloride in the form of physiologic saline solution would be necessary to restore the blood level to normal. A little more than this quantity of sodium chloride would be supplied by 2,000 cc. of physiologic saline solution. If such a deficit existed, the necessary saline solution should be replaced slowly over a twenty-four hour period either by the subcutaneous or oral route. If the carbon dioxide-combining power of the blood is appreciably lowered, 500 cc. of 5 per cent solution of sodium bicarbonate can be administered intravenously and the blood level determined again in twenty-four hours. An equal amount of one-sixth molar sodium lactate can be used in place of sodium bicarbonate.

Early bilateral exploratory trephination should be employed in selected cases in order to detect, and treat if present, the formation of subdural hematoma. The patients selected for this procedure fall into two categories. The first is made up of those patients who do not improve, but remain unconscious after five to seven days of observation. The second group comprises those patients who become conscious, but remain confused disorientated, or in whom hemiparesis develops. In another group of patients, namely, those who have been hemiplegic from the onset of their injury, air studies in the form of pneumoencephalography or ventriculography are to be considered in order to determine the presence of an intracerebral clot.

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Benign Ulcer of the Transverse Colon

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WHEREAS ulcers of the colon are relatively common, the incidence of ulcers of the transverse colon is extremely rare and a review of the literature covering a period of one hundred and thirteen years reveals only 2 previously reported cases, in 1 of which perforation had occurred prior to surgical treatment, and in 1 of which the ulcer was perforating at exploratory laparotomy and did perforate. A third case of simple ulcer of the transverse colon, without perforation, is presented at this time, the first case to be presented in the American medical literature. This case is doubly interesting in that the simple ulcer of the transverse colon was accidentally discovered during an operative procedure for severe and medically uncontrollable hemorrhage from a duodenal ulcer.

Report of a Case

The patient (W.R.) was a white man, 39 years old, who entered the Milwaukee County Emergency Hospital on Aug. 1, 1946, with vomiting of copious quantities of bright red blood, passing tarry stools, and complaining of a sour stomach. He gave a history of having had intermittent epigastric distress, mild abdominal pain, anorexia, loss of weight, and occasional nausea, but no vomiting for the preceding two years.

The present illness had begun on July 26, 1946, with nausea, epigastric distress, and a sour taste in his mouth. Three days later, he began to have loose tarry stools several times a day. Moderately severe abdominal pain also developed. Ingestion of food increased the abdominal pain so that for the previous twenty-four hours he had been taking only lemon juice and soda by mouth. On the day of admission to the hospital, he vomited large quantities of bright red blood over a two hour period, had a large amount of loose, tarry stool, and collapsed at home.

He was in a moderate state of shock on admission; he was dyspneic and had a pulse rate of 140, thready and weak; the skin was cold and clammy and the blood pressure was 66/0. Examination showed slight epigastric tenderness and dried blood about the oral and anal orifices, and a trace of tarry stool was present on glove following rectal examination. The remainder of the general examination showed nothing abnormal. The blood cell count revealed a secondary anemia with leukocytosis. A diagnosis of bleeding peptic ulcer was made, and treatment was instituted promptly.

The next twenty-four hours were uneventful. He responded to therapy and had no episodes of hematemesis or melena. For the next five days he had intermittent episodes of hematemesis and tarry stool on alternate days and usually vomited about 400 cc. of clotted bloody vomitus during a twenty-four hour period.

Six days after admission, he had two extremely large evacuations of loose tarry stool and manifested all the signs and symptoms of massive gastrointestinal hemorrhage. It was felt that conservative therapy had failed, and exploratory laparotomy under ether anesthesia was performed immediately. When the peritoneal cavity was entered, there was noted what appeared to be a large, annular carcinoma, 2 inches in length, on the right half of the transverse colon. The mass was freely movable. There did not appear to be any liver metastasis. For obvious reasons nothing was done to this mass at the time. An incision was made through the anterior wall of the duodenum. On the posterior wall of the duodenum there was a large crater ulcer, 2 cm. in diameter, and in its base was a large, pulsating, bleeding vessel, the pancreaticoduodenal artery. The vessel was ligated with a chromic catgut transfixion suture. The duodenal wall was closed with suture. Further inspection of the duodenum revealed that the ulcer had perforated following ligation of the pancreaticoduodenal artery. The duodenal perforation was closed with omental tags and Lembert sutures. The abdomen was closed in layers without drainage.

The first seventy-two hours postoperatively were uneventful; then the blood pressure dropped to 80/40, and he had a tarry stool and bloody emesis. The pulse was rapid, weak, and thready, and he was irrational. Undoubtedly the catgut ligature of the pancreaticoduodenal artery had become absorbed,

and the artery was bleeding again, a very good argument for the use of nonabsorbable suture material. His condition was critical and remained so for the next seventy-two hours, during which time he bled intermittently and moderately. A Meulengracht diet was instituted on the seventh postoperative day, and progress was uneventful until the fifteenth postoperative day, when wound separation occurred, involving only the skin and subcutaneous tissue of the upper 3 inches of the incision. On August 27 (twenty-sixth postoperative day) he was transferred to the Milwaukee County General Hosiptal. The next day he had severe abdominal pain and hematemesis again, and the blood pressure dropped to 86/52. The next four days his blood pressure ranged from a systolic pressure of 80 to 90 over a diastolic pressure of 50 to 60. He continued to have copious emesis of blood and tarry stools, and, while operation was desirable, it was inadvisable due to the patient's critical condition. The patient was able, however, to weather the storm and gradually improved under conservative management.

On October 2, the patient's condition being excellent, the operation for resection of the lesion of the transverse colon was done. It was noted, upon opening the peritoneal cavity, that the mass in the colon, noted at the previous operation, had decreased greatly in size and had become softer on palpation. It no longer felt like a malignant lesion. The involved segment of the colon was resected, and an end to end anastomosis was performed. The pathologist's report revealed the following: "The specimen consists of what apparently is a portion of transverse colon which has previously been opened. It measures 11 cm. in length and has a circumference of 9 cm. To the bowel there is attached a portion of omentum and multiple appendices epiploicae. At the midportion of the specimen there is a firm, depressed area with its long diameter transverse to the long axis of the bowel. This measures 4 x ½ cm.; it apparently extends through the mucosa, and about it there is an area of hemorrhage. On the serosal surface corresponding to the mucosal ulceration there is an area of dimpling and hemorrhage. On cut section through the ulcer tissue, it cuts with some difficulty, is homogenous white except at its extension to the serosa, where areas of hemorrhage are noted. Microscopic examination discloses a benign ulcer of the transverse colon with marked plasma cell reaction."

The patient's postoperative course was uneventful, and he was discharged from the hospital on October 19. He has regained his weight and returned to gainful employment. He is on a modified ulcer diet and except for occasional mild epigastric distress, has no complaints. A gastrointestinal x-ray series made on April 1, 1948, revealed no evidence of ulcer or gastric retention.

Discussion

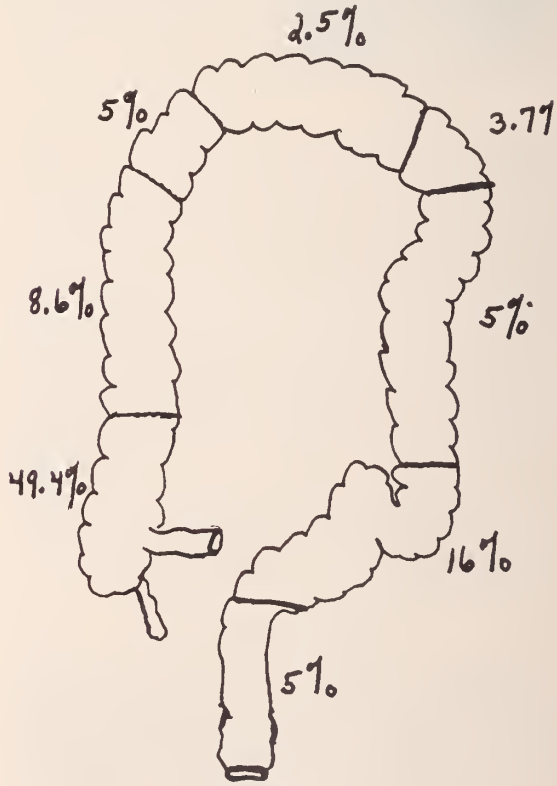
Probably the first description of the symptomatology of simple ulcer of the colon was by Cruveilhier in 1830, who reported that there was in the large intestine a simple ulcer whose fundamental characteristics bore a striking resemblance to those of a gastric ulcer. Further pathologic reports were made by Marchesseux in 1837, Rogee in 1838, and Lebert in 1855.

Quernu and Duval in 1902 published a monograph "L'Ulcere Simple du Gross Intestine," which gave a complete clinical description of simple ulcer of the large intestine. They reported 31 cases from the literature. The ulcer was single in two-thirds of the cases, but in the remaining one-third of the cases it was associated with analagous lesions in the stomach and duodenum. Of 3 cases, perforation occurred in 23.

Barron surveyed the literature in 1928, from 1837 to that time, and, of fifty-three simple ulcers of the colon, was unable to locate a single one involving the transverse colon.

As far as we have been able to ascertain, Delgado, in 1936, reported the first case of perforated simple ulcer of the transverse colon, and a year later, Helman reported the second case, which also perforated through the transverse colon.

Barlow (fig. 1) was able to collect 28 cases of simple ulcer of the colon, from the literature, and observed 2 additional personal cases, but none of these involved the transverse colon.



Cecum	49.4%	Splenic flexure	3.7%
Ascending colon	8.6%	Descending colon	5.0%
Hepatic flexure	5.0%	Sigmoid	16.0%
Transverse colon	2.5%	Rectum	5.0%

Fig. 1. — Barlow's listing of the location of simple ulcers of the cecum, colon and rectum (reproduced from the British Journal of Surgery 28:575, 1941).

The disease is usually more common in males than females, the ratio being made 2:1. The youngest patient reported in the literature was 18 years of age, the oldest 80 years old.

The etiologic agent varies, as does the cause of ulcers elsewhere in the gastrointestinal tract. Some of the theories expounded are as follows: inflam-

matory, circulatory, neurogenic, bacteriologic, toxic, digestive, or purely mechanical, foreign bodies, intestinal worms, and intestinal calculi. Many of the ulcers were in the sites of relative stasis, and reports stress the funnel-shaped perforating type with frequent erosion of muscle. The edge is often hard, relatively chronic, but the base is very active, suggesting a lesion of slow onset, suddenly become acute.

It appears to be difficult to discover any exact symptomatology. Usually there is vague abdominal pain and a history of long-standing constipation. The onset of a perforation of a colonic ulcer may be acute, sudden, and alarming and may appear in a person in perfect health without any prodromal symptoms, or in some cases it may follow a protracted period of undiagnosed intestinal disorders.

The diagnosis is extremely difficult to make before perforation has occurred. There are no pathognomonic signs by which the diagnosis can be made, and also, because of the extreme rarity of the disease, it is often unsuspected in an evaluation of the acute surgical abdomen. The first impression usually is a perforated appendix and less frequently a typhoidal perforation, a volvulus, a strangulation, or an invagination.

In the past, in cases of acute perforation of ulcer of the colon, the following operative procedures were used; (1) simple drainage—all patients died; (2) oversewing of ulcer with drainage—of 9 patients, 7 survived; (3) local excision with drainage —of 5 patients, 4 survived; (4) resection of whole area with anastomosis—of 11 patients, 10 survived; and (5) exteriorization and opening of diseased area —of 3 patients, 2 survived. In view of the foregoing results, it appears that when a simple ulcer of the colon can be treated surgically, resection of the whole area with anastomosis is the procedure of choice.

Summary

1. A case of simple benign ulcer of the transverse colon, in association with an intractable bleeding ulcer of the posterior wall of the duodenum is reported.

This is believed to be the first time that such a finding has been recorded in the American literature. Only 2 previous cases of perforated and perforating ulcers of the transverse colon have been reported in the foreign literature.

2. A brief discussion is presented covering the etiology, incidence, pathology, symptomatology, diagnosis and treatment of simple ulcers of the colon.

3. Ligation of the bleeding vessel of the peptic ulcer with absorbable suture material was followed in three days by recurrence of the hemorrhage. Nonabsorbable suture material should be used in these ligations.

4. This patient received forty-one transfusions of whole blood, consisting of a total of 19,800 cc. from August 1 to September 29, 1946, without any untoward effects.

Addendum

Since this article was submitted for publication, the patient has been re-admitted to the Milwaukee County Hospital on Dec. 26, 1949, complaining that for the past four months, besides some hematemesis, he began vomiting his food five minutes after eating and had severe boring pain in the midepigastrium. He was also suffering from malaise, anemia, and cachexia.

Roentgen examination showed a large ulcer at the pylorus and at laparotomy on December 30 (J. M. K.), this ulcer, 8 cm. in diameter was seen to be saddle-shaped and adherent to the undersurface of the left lobe of the liver and to the pancreas. Grossly, it felt like a malignancy. A Hofmeister modification of the Polya operation was done. The base of the ulcer could not be removed for obvious technical reasons. He made a good recovery following operation, with complete subsidence of symptoms. He is eating well and gaining weight. Histopathologic diagnosis was a benign gastric ulcer.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Newer Drugs in the Treatment of Herpes Zoster

Four patients in the acute stage of herpes zoster were given 250 mg. of chloromycetin orally every four hours for twenty-four hours by Dawson and Simon,[1] Birmingham, Ala. In each instance there was definite improvement in twenty-four hours, and after forty-eight hours disappearance of the pain and marked regression of the skin lesions. All progressed rapidly to complete recovery without residual neuritic pain.

Two patients with severe postneuritic pains were given chloromycetin in the same dosage but no improvement resulted.

Fisher, Zukerman, and Sweeny[2] (Riverside Clinic, Detroit) treated 3 patients with herpes zoster and 1 with intercostal neuralgia with tetraethyl ammonium chloride.

In the first case of herpes zoster there was complete relief of pain in one minute following intramuscular injection of 50 mg. of tetraethyl ammonium chloride, and the effect lasted six hours. Thereafter, because of the return of severe pain, the drug was given in 50 mg. dosage in the morning and at bedtime. After a few days it was required only once daily, and it use could soon be discontinued altogether.

In the second case of herpes zoster, the patient was given 200 mg. of tetraethyl ammonium chloride intravenously, with complete relief of pain, nausea, and hyperesthesia in fifteen minutes. Pain gradually returned after two hours. Four hours after the initial injection another of same size was given intramuscularly, with relief from pain in twenty-five minutes. Next day, dosage was 150 mg. intramuscularly, with pain relief for five to eight hours; thereafter this dosage was continued daily for one month. At the end of this time it was necessary to give 200 mg. every eight hours for several weeks, and then for a period of twelve days relief was obtained with 2 injections daily of 100 mg. each. Thereafter, for one month (to the time of the report) the patient had received 150 mg. intramuscularly 3 times daily with relief of pain for six to eight hours after each injection.

The third patient, suffering from intercostal neuralgia not relieved by salicylates, codeine, or pantopon, was given 50 mg. of tetraethyl ammonium chloride intramuscularly in the morning and at bedtime and had complete relief of pain for six hours after each injection. Two injections were given daily for twelve days (patient free of pain) and 50 mg. every other day for another six days, when all therapy was discontinued because of cessation of symptoms.

The fourth case was one of herpes zoster treated with 50 mg. of tetraethyl ammonium chloride intramuscularly with quick relief of pain. Next day, 100 mg. were given intramuscularly at bedtime with freedom from pain until 7 a.m., when patient was awakened by lancinating pain, relieved by taking codeine. Next day, 150 mg. of tetraethyl ammonium chloride were given at bedtime and there was no pain throughout the night and thereafter for three days. But several more 100 mg. injections at bedtime were necessary at intervals of several days before freedom from pain became permanent.

Fasting,[3] of New Orleans, reports the treatment of herpes zoster by sponging the involved area with a small amount of carbon tetrachloride on a cotton sponge. Prompt relief from pruritus is said to have occurred in the small number of patients treated. The author says toxicity need not be feared when the solution is dispensed in small amounts and used with the conventional precautions, but I am wondering, nevertheless, whether this therapy might not carry some hazard. Industrial experience in recent years has shown carbon tetrachloride to be a somewhat dangerous agent no matter what "conventional precautions" are taken. In swabbing it freely over the areas involved in an extensive case of herpes zoster under conditions often obtaining in the sick room, it is very likely that considerable amounts would be inhaled by both patient and attendant. Almost ridiculously small quantities of the substance have been known to cause severe poisoning.—HARRY BECKMAN, M. D.

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Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Serum Amylase and Lipase Determinations in Diseases of the Pancreas

Normal serum has a certain amount of amylolytic and lipolytic activity which is thought to arise in part from the acinar cells of the pancreas. Although other organs (salivary glands and certain intestinal glands) are known to release digestive enzymes to the serum, it seems that the extrapancreatic contributors *do not ordinarily* cause variations in amylase and lipase levels of a degree sufficient to destroy the usefulness of their measurement in acute conditions of the pancreas.

Serum Amylase

The modified test of Somogyi is favored by many laboratories. In this procedure 2 cc. of a 1 per cent acidified sodium chloride solution and 1 cc. of serum or plasma are added to a specially prepared starch solution. After an incubation period at 40 C. for thirty minutes, copper sulfate (1 cc. of a 5 per cent solution) and sodium tungstate (1 cc. of a 7 per cent solution) are added. The mixture is shaken and filtered, and an aliquot of the filtrate is tested for glucose. Correction is made for the presence of reducing substance (glucose) of serum and substrate and the final result is expressed in units, each unit being equivalent to 1 mg. of glucose liberated per hundred cubic centimeters of serum. Normal values range from 80 to 150 units with values below 60 and above 200 being considered abnormal.

To be of real diagnostic value in acute pancreatitis it is imperative that determinations be carried out as soon as possible after the onset of illness, because it is not unusual for high values to fall to normal or even below normal within two or three days, even though symptomatology has not subsided. At the height of an acute attack of pancreatic obstruction or inflammation values of from 1,000 to 3,000 units may be reached.

Occasionally, in cases of rapidly progressive acute pancreatic necrosis, blood amylase levels may be normal or actually depressed, because at the time of blood collection little or no secreting parenchyma remains.

In order to keep this valuable test from falling into disrepute, it is important to remember that increased serum amylase values must be carefully correlated with the history and other clinical findings. Moderate elevations may be obtained in posterior perforating peptic ulcers, in high perforations of the gastrointestinal tract associated with a severe generalized peritonitis, in renal failure, in acute alcoholism, in acute inflammations of the salivary glands, and in occasional cases of infectious mononucleosis.

Low blood levels may be seen in certain liver conditions and in cases of pancreatic fibrosis.

A laboratory prepared to carry out this procedure at regular intervals can complete a test in about an hour.

Serum Lipase

Many laboratories have been far from satisfied with the procedures commonly recommended for serum lipase determinations, because results have been so erratic. Attention, however, is called to the Crandall and Cherry test as modified by Elizabeth Maclay of the Mayo Clinic. In Miss Maclay's procedure (1948) an improved olive oil emulsion is mixed with 1 cc. of serum and a veronal buffer and is incubated for eighteen hours. Values are expressed in cubic centimeters of tenth-normal sodium or potassium hydroxide required to neutralize the fatty acids liberated in the reaction.

Normally, the serum lipase activity is low, the titration values usually falling between 0.6 and 0.9 cc. (extreme range of variation 0.2 to 1.5 cc. per 1 cc. of serum).

Serious objection has been raised to the use of the lipase test in acute pancreatitis because of the time required for its performance. It should be emphasized, however, that this test, unlike the amylase test, remains elevated for periods of ten to fourteen days or longer after the onset of an acute attack and may continue to be increased for months in the presence of chronic disease of the pancreas. Levels as high as 10.2 cc. have been observed by Comfort during acute phases.

Normal amylase and increased lipase values have been reported in about half of the cases of carcinoma of the pancreas and carcinoma of the ampulla of Vater. Similar findings have been found in a small per cent of cases of chronic biliary tract disease (inflammation, stone, stricture, carcinoma), duodenal ulcer, hepatitis, and cirrhosis of the liver.

Glycosuria and Hyperglycemia in Acute Pancreatitis

In some cases of acute pancreatitis glycosuria and especially hyperglycemia may be found. Reliance may be placed on these findings only if pre-existing diabetes can be excluded.—W. H. JAESCHKE, M. D.

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As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

C. N. NEUPERT

A native of Wisconsin, Doctor Neupert took his premedical training at the University of Wisconsin and was graduated from Washington University School of Medicine in 1925. He was in private practice for ten years before joining the State Board of Health. He earned the degree of M.S.P.H. from the University of Michigan in 1941 and has been State Health Officer since 1943.

Why did she let this go into the late stages of disease before coming for help? How many times have you raised that question? You hope her cancer of the uterus can still be eradicated, but you can't be sure for many months. How much more certain and how much simpler if she had presented herself early in the disease!

Or, an older man comes in complaining of a chronic cough. He comes in now because he has recently become hoarse. You find advanced pulmonary tuberculosis. You worry about the exposure of grandchildren living in the same house. How much better for him, but especially for the youngsters, if his tuberculosis could have been diagnosed when chances of recovery were brighter and before the children were exposed!

Or, you're called to see a patient in diabetic coma and it's touch and go whether you can bring him out of it; and if you can, there is that complicated matter of establishing balance between carbohydrate intake and insulin dosage for the rest of his life.

Early detection would have avoided so much risk and probably the drastic regimen for the patient.

Through the years we have searched for an effective way to get at diseases in their early stages. It has involved seeing people when they were apparently well. Our best proposal was periodic health examination—annually, we've said.

But, to find "early disease" requires a searching examination requiring laboratory, and often x-ray services that are costly. They seem especially costly to the patient if the result is an assurance that he is in reasonably good health and he is faced with repetition of that expenditure each year—the annual physical examination.

The knowledge and skill of the attending physician and the auxiliary diagnostic aides he had found necessary are worth while. Many more people could be reached, however, if those talents and the cost could be applied to patients inexpensively screened out from large groups of apparently well people. Sink shafts where there is likely to be oil in the substrata.

There is only an incomplete solution to this problem at present, but it is a step in the right direction. There are screening technics for early tuberculosis by means of the 70 mm. x-ray; diabetes can be detected early by a "micro method," using but a drop of blood; unsuspected heart impairment can be picked up on the miniature x-rays in many instances.

Programs of this type are underway in at least three states wherein technicians, not physicians, are screening the general population—apparently healthy people—for leads as to possible early disease. Those with evidence of possible disease are referred to their family physician for positive diagnosis and for whatever medical care is indicated.

These programs, reported in recent issues of the *Journal of the American Medical Association* are being carried out in cooperation with the medical societies: state and local. Several tests, those agreed upon, are carried out during the one visit of the prospective patient at the center.

The procedure is referred to as "multiphasic screening," for want of a better term. By applying the several tests at one visit, separate trips are avoided to participate in a tuberculosis survey today, a diabetes survey at another time, and a cancer detection service where applicable on another. In some, blood pressure is taken to screen hypertension. Screening for early heart disease is less well developed than some of the others. All are limited in their completeness but give definite promise of finding disease in it early stages in apparently well people beyond what is possible now.

For those patients who appreciate the importance to them of taking every reasonable precaution and who want to have a complete annual inventory of their health, the more complete, more individual annual examination by their physician is the answer. For the many others not now taking advantage of this service, the screening technic outlined above is much better than nothing.

Isn't this another opportunity for physicians to show leadership in the advancement of public health? It's worth looking into in Wisconsin.—CARL N. NEUPERT, M. D., *State Health Officer.*

. . . . The President's Page . . . .

Shock Therapy

IT IS axiomatic that an organization has worth to a member in direct proportion to his investment in it. For many in the medical profession, the great value of the American Medical Association, and the state and county societies, has been found in pride and in hard work.

For some, shock therapy may be found in the fact that for the first time in its history, active members of the American Medical Association are now asked to pay dues.

Perhaps this will bring about an interesting trend.

The fine work of the American Medical Association will be viewed more keenly by many physicians in this country. Increasing numbers of medical men will find themselves willing to contribute to the work of its committees, its sections, and its councils.

Indeed, it will doubtless be found that many more physicians will read the various news stories that periodically appear concerning their national organization and its views.

The $25.00 membership dues are unquestionably necessary if the American people are to be properly informed on current economic proposals. And perhaps as great a value will lie in the energizing influence it will bring to bear upon great numbers of the membership of the American Medical Association.

John Wm Truitt MD

Proceedings of the Milwaukee Academy of Medicine December 20, 1949

Fundamental and Clinical Aspects of Liver Disease*

By CECIL J. WATSON, M. D.
Minneapolis

WHEN one reflects that a recent survey has brought forth the astounding fact that there are at least 500 separate functions of the liver, I think it is evident that one must limit one's remarks to a very small segment of the topic. My associates and I have been interested more particularly in pigment aspects of the problem for a number of years, so I will give more emphasis to that side of the subject. However, I should like to consider the problem of jaundice in relation to liver disease, that is, jaundice as to differential diagnosis, and some of its fundamental mechanisms, and then to close with a brief discussion of some of the things that I think are most interesting in relation to the problem of portal cirrhosis.

Bilirubin is the principal pigment of the bile and is formed by the destruction of the old red blood cells, which are destroyed most probably in the reticuloendothelial system of the liver, spleen, bone marrow, and lymph nodes. This bilirubin is brought to the liver and is excreted into the bile. As it comes to the liver, it is rather tightly bound to a protein. The character of this protein is, to me at least, one of the remaining mysteries and one of the most interesting problems that needs more investigation. There is a good deal of reason to believe that the protein is the original globin of the hemoglobin molecule that has not become detached. Recent evidence has shown that, in the catabolism of hemoglobin, the first step is the opening of the protoporphyrin ring. The iron in the globin is not removed in the first step. Next, the iron is brought out, but no evidence has been presented, at least at all conclusively, that the globin is split off. In fact, the majority of the available evidence indicates that the globin is still attached, and that the bilirubin, which is brought to the liver cell, is still attached to its original globin. This substance, which is called bilirubinglobin, gives an indirect or delayed Van den Bergh reaction. After the bilirubin gets across the liver cell barrier and into the bile capillary it is no longer connected with protein. It is now a simple sodium bile salt and in this form normally passes down through the biliary duct system into the duodenum.

If there is obstruction in the biliary tract, producing an increase in intrabiliary pressure, and injury of the intrahepatic cholangioles, then bile gains access to the blood. There is good evidence for this, and that it is actually regurgitated back via the lymph into the blood. This can happen not only from biliary obstruction, such as stone or neoplasm, but from anything which injures the intrahepatic cholangiolar system. The sodium bilirubinate, which may regain access to the blood under these circumstances, is characterized by a prompt Van den Bergh reaction, a reaction that occurs for the most part within one minute. This is in contradistinction to the original bilirubinglobin, which reacts only in a very delayed fashion or only after the addition of alcohol or acetone to the blood serum, the so-called indirect reaction.

We like to use the fundamental classification of jaundice which Arnold Rich proposed, that of retention jaundice in which the bilirubinglobin is retained and is not excreted into the bile as rapidly as it should be, thus piling up in the blood stream. In this form we have a delayed or indirect Van den Bergh reaction and one does not have bilirubin in the urine, because this form of bilirubin does not go over into the urine. We have seen individuals with as high as 15 mg. of this form of bilirubin, without any bilirubin in the urine. Conversely, we have found, especially in the early stage of cholangiolar injury as in infectious hepatitis, bilirubin appearing in the urine when even the prompt Van den Bergh reaction reaches as slight an elevation as 0.4 mg., the upper limit of normal for this type being 0.2 mg. per hundred cubic centimeters, so that in incipient jaundice bilirubin appears in the urine at a very slight elevation of this type of Van den Bergh reaction. Later on, in the convalescent period of hepatitis, for example, the bilirubin in the urine may disappear at a somewhat higher level, usually around 0.8 to 1.0 mg. of the prompt, direct reacting type.

It is important to have a simple test for bilirubin in the urine, with particular reference to the problem of infectious hepatitis, because one can often detect the disease in the incipient stage by means of a simple test for bilirubin. Thinking particularly of war and of concentration of troops, where hepatitis may be encountered in great numbers, it is very useful to have a simple test for bilirubin in the urine. Such a test was first suggested by Turner and is known as the barium filter strip test. It is a modification of Harrison's test. These strips of filter paper are impregnated with barium chloride and they are held briefly in the urine sample. The

* The complete paper by Doctor Watson is available from the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3.

urine runs up the strip to the point of the surface of the urine, and at that point the bilirubin collects. If one then drops at that line a drop of Fouchet's reagent, which contains trichloracetic acid and a little ferric chloride, one obtains a transition of the orange–brown bilirubin to the green biliverdin. This constitutes quite a delicate test for bilirubin in the urine. This is one of the two bedside tests for disease of the liver and the biliary tract.

In retention jaundice then, we have an hepatocellular inability to remove bilirubinglobin from the blood as rapidly as it is formed, and that, of course, is typified in hemolytic jaundice. The amount of retention, however, varies a great deal from case to case. There are some instances of hemolytic anemia without jaundice, in which the liver is very snappy in its function and passes over every bit of the bilirubin just as fast as it is formed. There are other cases which have marked jaundice, with a sluggish liver function. Interestingly enough, the latter type usually has much less anemia. Whether there is a direct correlation or not remains to be established, but at least the clinical correlation is correct. Retention jaundice is also encountered in the disease known as constitutional hepatic dysfunction, in which there is no overproduction, no increase in hemolysis, but simply a sluggish state of the liver cells with respect to passing the bilirubin over to the bile. These individuals have the same kind of Van den Bergh exactly as one encounters in hemolytic jaundice, and they must be distinguished on the basis of other determinations. Then there are cases of minimal hepatocellular injury, as one sees, for example, in cardiac failure, especially if there is a pulmonary infarct with increased destruction of red blood cells in the infarct.

Regurgitation jaundice can be defined as a cholangiolar leakage of bile into the lymph and then to the blood. It should be emphasized that regurgitation jaundice may be medical, as well as surgical. In fact, it is often medical. This is all too commonly lost sight of. It has been sort of a tradition in the past that if a patient has bilirubin in the urine and a prompt, direct Van den Bergh reaction, he has surgical jaundice. I would emphasize that this is often not correct. In my opinion, there are more cases of medical jaundice of regurgitation type, actually, than there are surgical. This is especially true should there be an epidemic of hepatitis, because nearly all cases of infectious hepatitis at some stage of the disease have regurgitation jaundice. Other causes of severe or moderate hepatic injury of various types are also associated with regurgitation jaundice. That is also true of hepatic cirrhosis, of some cases of diffuse hepatic carcinomatosis, or Hodgkin's disease. Surgical jaundice is due to extrahepatic biliary obstruction, such as cancer and related conditions, calculus, stricture with or without secondary biliary obstructive cirrhosis.

Now to go on with our cycle of the bile pigments very briefly, we have taken the sodium bilirubinate into the bile, on into the duodenum and down the intestinal tract, where it is reduced in the colon by the bacterial flora. Recent studies in our laboratory have shown that one can completely abolish this reduction with aureomycin. It is possible, in an individual who has no liver or biliary tract disease whatever, to eliminate urobilinogen from the feces, so that the amount of urobilinogen in the feces will be that which is characteristic of a complete biliary obstruction. This is accomplished by eliminating bacterial activity in the colon, which ordinarily reduces bilirubin to urobilinogen. The term, urobilinogen, encompasses at least two separate chemical constituents. Recent studies have indicated that there is probably a third, although in very small amounts. The two main ones are mesobilirubinogen, which is then further reduced to stercobilinogen. Fortunately, these give the same intensity of color Ehrlich–aldehyde reaction, the commonly used test for urobilinogen. Therefore, we can speak of them from the clinical standpoint under the name which is time-honored, namely, urobilinogen. A considerable amount of urobilinogen formed in the colon is reabsorbed in the peripheral circulation. This is promoted by constipation, which results in filling of the colon with feces. The more filling there is, the more time there is for reabsorption, and the larger the fraction that goes back to the liver. In the presence of diarrhea or more rapid peristalsis, the amount of reabsorption is smaller. Of course, if the diarrhea is extreme, as, for example, in cholera or severe bacillary dysentery, there may be bilirubin coming out without any reduction whatsoever, since there is no time for reduction to urobilinogen. Under ordinary circumstances, the urobilinogen which is absorbed from the colon goes back to the liver and is largely metabolized, at least as far as we can determine. Very little of this reappears in the bile. Only a small portion finds its way into the general circulation. Under normal circumstances not more than 3 mg. in twenty-four hours appears in the urine, but in the presence of even transitory hepatocellular impairment in most instances, but not always, the amount of urobilinogen in the urine increases, and may increase to a very remarkable extent. Kidney function may alter this, for if we have renal insufficiency, urobilinogen is retained, just as is urea. Therefore, in the presence of renal disease, the absence of urobilinogen in the urine may not be significant. A simple test for urobilinogen in the urine is the Ehrlich–aldehyde reaction, which is chiefly for urobilinogen and is the second of the two bedside liver function tests, the barium strip test for bilirubin being the first. The test is applied by simply mixing an equal part of urine with an equal part of Ehrlich reagent and then two parts of the saturated solution of sodium acetate. This brings out the maximum color reaction, if any reaction occurs.

We find that if the urine bilirubin reaction is strong and the Ehrlich is negative, we can be sure that we have regurgitation jaundice, which may be either medical or surgical. We know at least that there is little or no bile entering the intestines. If,

on the contrary, we find that the urine Ehrlich test is 4 plus and the bilirubin is 0, then we can be quite certain that the condition is either retention jaundice or liver disease without jaundice. This situation is often found in hemolytic jaundice, but it is also found in hepatic cirrhosis, and quite a few cases of hepatitis after the jaundice has disappeared. If we find that the urine contains both bilirubin and urobilinogen in fairly plentiful amounts, we can be sure that we are dealing with regurgitation jaundice, which is more likely medical in character, either hepatitis or cirrhosis. We prefer, when we can, to obtain more accurate quantitative data with respect to urobilinogen excretion. The urobilinogen content in the feces in hemolytic jaundice is markedly increased. This is one of the most characteristic and constant features. It may be normal in the urine. In constitutional hepatic dysfunction, the feces urobilinogen is normal and the urine urobilinogen is hardly ever increased appreciably. In regurgitation jaundice due to biliary tract cancer, 90 per cent of the patients have less than 5 mg. of urobilinogen in the feces and less than 0.3 mg. in the urine per day. These findings suggest complete obstruction; whereas, in the calculus group, 90 per cent have more than 5 mg. of urobilinogen in the stool in a twenty-four hour determination. In most of the cases with stones causing jaundice, there is not complete obstruction. There is usually an increase in the urine, especially if the patient has complications, such as cholangiolitic fever or biliary cirrhosis. In the group with hepatitis, cirrhosis, or other diffuse liver disease, there is usually more than 5 mg. per day, but in infectious hepatitis it is common to have the amount go down into the so-called cancerous range, for several days or even weeks, especially at the height of the disease. In the urine we have from 0 to 300 mg., a tremendous variation. This is a very dynamic condition, of course. During the height of the disease, when little or no bile is entering the intestine, we may have no urobilinogen in the urine. Then as the patient begins to get better, characteristically urobilinogen returns and may be present in large amounts for a variable period of time. This is often the most helpful sign in detecting the beginning improvement.

Laboratory tests for the purpose of differential diagnosis of jaundice, are for the most part directed at revealing evidences of hepatocellular functional impairment. We do not have any good tests for Kupffer cell function. It may be that some of the qualitative protein tests relate to Kupffer cell function, but that is still a doubtful question. With increasing hepatocellular function impairment, in which there is often a tendency toward edema or ascites formation; the cholesterol, phosphatase, bile acids, and albumin all tend to go down. This is sort of a rule of thumb that is extremely helpful in the differential diagnosis of jaundice. Because of the striking dissociation of liver functional impairment that may occur from case to case, it is necessary, in many instances at least, to get a composite picture of liver function, rather than to try and rely on just one or two tests. We have been very much interested in the coproporphyrin excretion in cases of cirrhosis of the liver. Unfortunately, the methods for determining the urinary coproporphyrins at the present time must be regarded as research tools. There are two coproporphyrin isomers in nature. There are actually four isomers, but only two occur in nature, types 1 and 3. Types 2 and 4 have never been found in nature. Types 1 and 3 both occur in normal urine but type 1 predominates. About 60 to 80 per cent is type 1 and the remainder is type 3. The upper limit of normal for the total is about 100, with the method that we have been using. In portal cirrhosis, with a history of chronic alcoholism, there has been observed an increase of the type 3 coproporphyrin. In the non-alcoholic portal cirrhosis, with fatty and infectious, and those of non-fatty type, there has been observed an increase of the type 1 coproporphyrin.

Introducing the Guest Editorialist

It has been my pleasure to know Congressman John B. Bennett since December 1932, when he brought one of his children to my office for an examination. I have been in close contact with the Congressman since that time. A close friendship has developed out of our professional acquaintanceship.

I have found the Congressman to be a most devoted father and one of the most conscientious lawmakers and representatives in the Congress. We have enjoyed a number of fishing and hunting trips together. However, a large number of planned trips have been cancelled because of unexpected developments in the Congress or because of other Congressional matters which demanded attention, which always received the first consideration from Mr. Bennett.

We have had a great many discussions in Ontonagon, in Milwaukee, in Washington, D. C., and elsewhere concerning the welfare of the public. Mr. Bennett is always seeking information which could be used for the welfare of his country. He has a very broad-minded approach to the problems of social legislation. I am glad to say that he is a decided individualist, a loyal citizen, and a true patriot.—*M. G. Peterman, M. D.*

The Federal Government and National Health

THE responsibility of the federal government for the health of the American people and the extent to which it should function in the field of public health has precipitated a bitter controversy in Congress and throughout the country. These are two extremes in this controversy—those who favor the President's program, which would take over the medical profession and its related functions, lock, stock, and barrel and regiment the individual citizen in matters pertaining to his health; and the other, which holds the federal government has no business concerning itself with any of the health problems of the individual American family. For those who are able to view this question with reasonableness and objectivity there is a middle ground.

Two economic groups of our citizens are reasonably provided for from a medical standpoint. The first group consists of the well-to-do, who are able to pay for all medical services they need or desire, although it is fair to say that this group is gradually becoming extinct by virtue of present tax laws. The second group consists of the poor, who are given medical care on the basis of public support and private charity, supplemented by gratuitous services of the average physician.

But there is a third group, made up of the average working man and his family, which comprises the main element of our population. This group is not as well provided for in all respects as either of the two other classes. It is true that great progress has been made in recent years in providing adequate medical care for members of this economic group, as, for example, through Blue Cross and Blue Shield and through joint labor-management health care. However, none of these protective devices give satisfactory protection to the average American family against calamity illnesses. This is the type of illness which leads to catastrophic medical expenses beyond the financial ability of such families to pay.

The ordinary family budget can stand routine medical bills. It can provide for Sally when she has the measles or for Johnny when he needs a tooth filled. But this budget cannot stand for disasters. Too often it cannot meet the financial burden of serious surgical treatment or prolonged hospitalization and medical care. Such emergencies create financial hardship which in many cases disrupts the family budget beyond repair.

I think the federal government can help solve this problem by acting as the insurer against calamity sickness. The government can collect its premiums to pay for such insurance by the simple method of payroll deductions or direct contributions in the case of the self-employed, on an actuarial basis, with premiums geared to the risks assumed. Such a plan would be preferable to voluntary methods working toward protection against catastrophic medical expenses, which cannot be successful because the coverage is distributed among too few and the premiums are necessarily prohibitive. Moreover, under such plans those who need coverage the most are least likely to have it. What is needed is broad and extensive coverage in terms of the numbers of people protected in order to diversify the risks and minimize the cost to those insured.

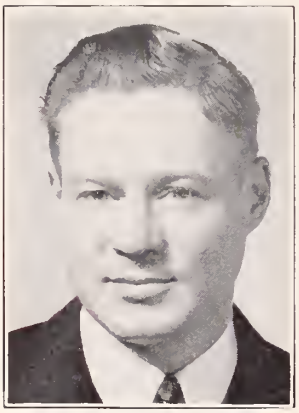
This plan is based on the assumption that the average American family can take care of its ordinary medical problems without government interference or assistance. It assumes that the medical profession is doing a good job and will continue to do so without control from Washington. It recognizes, however, that the federal government can help protect the citizen against extraordinary medical bills. It recognizes that this can be done in a manner sound in principle and consistent with our free enterprise system.

The standards for such calamity insurance would be specifically written in the law just as an insurance company writes its policy. There would be a minimum of administrative costs and control. There would be no need for an army of bureaucrats to harass the citizen. Finally, the plan would provide the answer to a very vital need without making every doctor a federal bureaucrat and without putting either doctor or patient in a "political straightjacket."

John B. Bennett

1950 ANNUAL MEETING PLANS

■ V. F. LANG, M. D., Milwaukee
Section on Internal Medicine



■ J. F. EGAN, M. D., La Crosse
Section on Obstetrics and Gynecology

■ E. J. ZEISS, M. D., Appleton
Section on Ophthalmology and Otolaryngology

DATES: October 2–3–4

HEADQUARTERS: Hotel Schroeder, Milwaukee

★

PROGRAM CHAIRMAN: F. W. Madison, M. D., Milwaukee

DIRECTOR OF SCIENTIFIC EXHIBITS: T. O. Nuzum, M. D., Janesville

DIRECTOR OF MOTION PICTURES: H. K. Tenney, M. D., Madison

★

Preliminary plans have been made for the 1950 Annual Meeting, and will be announced in the June issue of *The Wisconsin Medical Journal.* Section chairmen whose pictures appear on this page have assisted the Council on Scientific Work with the preparation of the scientific program, and all indications point to a meeting of great professional interest to members of the State Medical Society.

Delegates and officers are reminded that in making their hotel reservations the following scheduled events should be borne in mind:

The Council will meet on Saturday evening, September 30. The first session of the House of Delegates will be held on the afternoon of Sunday, October 1.

The most outstanding feature of the 1950 Annual Meeting will be the marked expansion of direct teaching programs, and the presentation of fewer formal papers. Each morning from 9:00–10:20 the scientific program at the Milwaukee Auditorium will consist of special demonstrations and clinics. Each day there will be an OB Manikin Demonstration, a Pathologic Conference, a Demonstration on the Treatment of Fractures, a Radiologic Clinic with Interpretation of X-Rays, an Anatomy Exhibit, and a Demonstration on Transfusion Technics (including a demonstration of blood replacement in the treatment of erythroblastosis).

Mark the dates on your calendar: October 2–3–4, for three days of scientific study at Milwaukee.

★

Special Note on Scientific Exhibits: All applications for exhibit space must be filed before May 1. See the next page for an application form and directions for mailing.

■ K. B. McDONOUGH, M. D., Madison
Section on Pediatrics

■ H. H. WRIGHT, M. D., Milwaukee
Section on Radiology

■ FORRESTER RAINE, M. D., Milwaukee
Section on Surgery

OFFICIAL CALL FOR

Scientific Exhibits

★

1950 ANNUAL MEETING MILWAUKEE OCTOBER 2–3–4

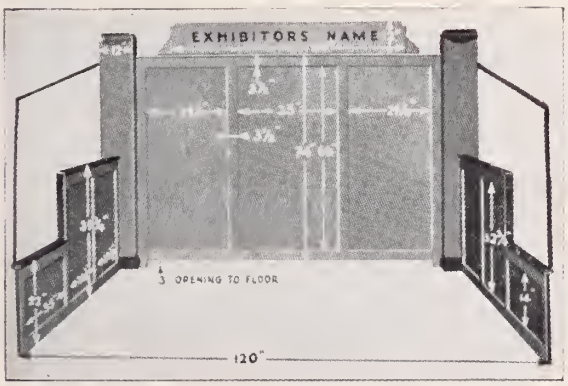
★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1950 Annual Meeting. The exhibits will be located in the main arena of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1950 meeting are requested to file an application BEFORE MAY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Wooden booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, and special lighting equipment required for this display.



In connection with the display of exhibits furnished by individuals outside of Wisconsin, the same rules as noted above will apply, but, in addition, the State Medical Society will provide hotel accommodations and reimburse the exhibit attendant for his travel, meals, and incidental expenses.

Booths for scientific exhibits are constructed of light green wood, in the dimensions shown on the chart at the left, *with this exception:* The side panels used for the exhibits of the State Medical Society are 6′ 5″ high and 9′ long.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by May 1. No applications can be accepted after that date. Address your communications to T. O. Nuzum, M.D., director of scientific exhibits, % The State Medical Society of Wisconsin, 704 East Gorham Street, Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1950 ANNUAL MEETING MILWAUKEE OCTOBER 2-3-4

Fill Out and Mail to:

T. O. NUZUM, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
704 East Gorham Street
Box 1109
Madison 1, Wisconsin

1. Title of exhibit: _____

2. Description of exhibit (attach 200 word description to this blank): _____

3. The standard booth is 10′ x 10′. _____

   How many booths will your display require? _____

4. Will radiologic viewing boxes be needed? If so, will you furnish them? _____

   (The State Medical Society does not have equipment of this character available, but it can be rented by the exhibitor through the Advertising Display and Decorations Company of Cleveland, Ohio)

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

EXAMINERS IN THE BASIC SCIENCES SCHEDULE EXAMINATIONS

The next two examinations of the Wisconsin State Board of Examiners in the Basic Sciences have been scheduled as follows:

April 1, 1950: 8 a. m. to 5 p. m. at the Assembly Chamber, State Capitol, Madison. The last filing date is March 25.

June 3, 1950: 8 a. m. to 5 p. m. at the Plankinton House, Milwaukee. The last filing date is May 27.

INDUSTRIAL HEALTH CLINICS

■ D. E. DORCHESTER, M. D.
Chairman, Committee on Industrial Health

3 PLANT CLINICS

■ CONSOLIDATED WATER POWER & PAPER, WIS. RAPIDS

■ KOHLER MANUFACTURING CO., KOHLER

■ GLOBE-UNION, MILWAUKEE

The Committee on Industrial Health, in cooperation with the Industrial Hygiene Unit of the State Board of Health and the Milwaukee, Sheboygan, and Wood County Medical Societies, is sponsoring three important medical meetings as described below. These meetings are open to members of the State Medical Society of Wisconsin, the industrial nurses of Wisconsin, and to special guests of industry.

Reservations must be made in advance! The only cost is that of dinner. All other expenses, including reimbursement of speakers, is provided by the State Society and the State Board of Health.

Your participation in these meetings is urged.

— April 13 —

KOHLER MFG. CO. PLANT **KOHLER**

1:45 p. m.: Registration—Recreation Hall in Kohler Village (Recreation hall located at the corner of High Street and Highway 23. A sign will direct you to the exact location)

2:00 p. m.: Briefing of tour by Dr. H. N. Heinz and Mr. L. C. Conger, assistant secretary of the Kohler Company

2:15–3:30 p. m.: Plant Tour. The tour will cover the foundry, both new and old, the enameling processes, and other portions of the plant which have not been viewed by previous tours of physicians.

SCIENTIFIC PROGRAM

(In the Ratzkeller of the Recreation Hall)

4:00 p.m.: "The Treatment of Electric Burns": Ernest Miller, M. D., Milwaukee

4:30 p.m.: "The Treatment of Hand Injuries": William Frackelton, M. D., Milwaukee

5:00 p.m.: "Industrial Dermatosis": Clifford Kalb, M. D., Milwaukee

DINNER—6:30 P. M. WISCONSIN ROOM OF THE AMERICAN CLUB

SPEAKERS: A Representative of the Kohler Co.

"Industrial Safety": A. J. Matthias, Circuit Instructor in the Field of Supervisory Training, Wisconsin Schools of Vocational and Adult Education

"Managing the Cardiac in Industry": Chester Kurtz, M. D., Madison

(REGISTRATION AND DINNER: $3.00)

April 20

CONSOLIDATED WATER POWER AND PAPER CO. WISCONSIN RAPIDS

1:45 p. m.: Registration at the Main Plant (watch for signs)
2:00 p. m.: Briefing of tour by Mr. George Nelson, director of safety, Wisconsin Water Power and Paper Co.

2:15–3:30 p. m.: Plant Tour. The plant tour will cover all of the industrial processes in the production of coated stock paper, and a brief tour of the power plant. The tour will be planned to highlight sources of injury and exposures as revealed by accident records of the plant.

AFTERNOON SCIENTIFIC PROGRAM

(In Conference Room of Main Plant)

4:00 p.m.: "The Treatment of Electric Burns": Ernest Miller, M. D., Milwaukee

4:30 p.m.: "The Treatment of Hand Injuries": William Frackelton, M. D., Milwaukee

5:00 p.m.: "Industrial Dermatosis": Clifford Kalb, M. D., Milwaukee

DINNER—6:30 P. M. ELKS CLUB

SPEAKERS:

"Industrial Safety": A. J. Matthias, Circuit Instructor in the Field of Supervisory Training, Wisconsin Schools of Vocational and Adult Education

"The Management of the Cardiac in Industry": Chester Kurtz, M. D., Madison

(REGISTRATION AND DINNER: $3.00)

May 3

GLOBE-UNION (900 E. KEEFE AVE.) MILWAUKEE

1:15 p. m.: Registration (in cafeteria facing East Keefe Avenue)

Note: **If your name begins with the letters A–M inclusive, please report for registration and briefing *before 1:30*. If your name begins with the letters N–Z please report for registration and briefing at 1:45.**

2:00–3:30 p. m.: Plant Tour. The plant tour will cover a variety of exposures and illustrate in particular the controls used to protect the workers from such hazards as lead poisoning. Be sure that you take the plant tour, as it will be directly related to the scientific program.

SCIENTIFIC PROGRAM

(Sky Room—Hotel Plankinton)

Chairman: D. E. Dorchester, M. D., Chairman, Committee on Industrial Health, State Medical Society

4:00 p.m.: "The Treatment of Hand Injuries": Harvey S. Allen, M. D., Associate in Surgery, Northwestern University Medical School, Evanston, Ill.

4:30 p.m.: Discussion and questions

4:45 p.m.: "Toxic Solvents": Elston Belknap, M. D., Milwaukee

5:15 p.m.: Discussion and questions

DINNER—6:15 P. M. SKY ROOM, HOTEL PLANKINTON

Ernest Miller, M. D., Milwaukee, Toastmaster

DINNER SPEAKERS: "Industry Looks at the Doctor": B. A. Krawczyk, Director of Compensation Dept., Allis Chalmers Mfg. Co., Milwaukee

"Industrial Aspects of Heart Disease": LeRoy H. Sloan, M. D., Professor of Medicine, University of Illinois Medical School, Chicago

(REGISTRATION AND DINNER: $3.50)

Society Proceedings

Barron—Washburn—Sawyer—Burnett

Dr. R. W. Adams of Chetek was named president of the Barron–Washburn–Sawyer–Burnett County Medical Society when that organization held its annual business meeting on December 13. Officers who will serve with Doctor Adams are *Drs. D. V. Moen*, Shell Lake, vice-president; *Allan G. Johnson*, Rice Lake, secretary; *N. A. Eidsmoe*, Rice Lake, delegate; and *G. A. Fostvedt*, Barron, alternate delegate. *Dr. James F. Maser* of Rice Lake was elected to the board of censors.

Brown—Kewaunee—Door

J. R. GOELZ

The January meeting of the Brown–Kewaunee–Door County Medical Society was held at the Beaumont Hotel on January 12. *Dr. J. R. Goelz*, Green Bay, discussed his recent European trip, illustrating his talk with colored kodachromes.

At the December meeting of the Society, also held at the Beaumont Hotel, *Dr. D. E. Dorchester*, Sturgeon Bay, was installed as 1950 president. *Dr. V. F. Neu* was named president-elect; *Dr. John J. Boersma;* vice-president; *Dr. G. M. Shinners*, secretary–treasurer; *Drs. W. A. Killins* and *O. W. Saunders*, delegates; and *Drs. L. D. Quigley* and *E. M. Jordan*, alternate delegates. All are from Green Bay. *Dr. F. J. Gosin*, also of Green Bay, was named censor for a three year period. Guest speaker at this meeting was Dr. Philip Thorek, assistant clinical professor in the department of surgery at the University of Illinois College of Medicine. Doctor Thorek discussed "Intestinal Obstruction," illustrating it with a colored movie.

Chippewa

Meeting at the Hotel Northern in Chippewa Falls on December 6, members of the Chippewa County Medical Society heard talks by two staff members from the Mayo Clinic in Rochester, Minn. Dr. M. B. Coventry discussed "Brucellosis of Bones and Joints," and Dr. G. W. Daugherty presented a paper on the "Management of Acute Renal Insufficiency." At the business meeting it was decided that an Auxiliary to the Chippewa County Medical Society should be formed.

Crawford

Members of the Crawford County Medical Society gathered at Geisler's Blue Heaven in Prairie du Chien for a dinner meeting on January 18.

Members of the Auxiliary to the Society were guests at a meeting held in Kaber's Jungle Room in Prairie du Chien on December 15.

Dodge

Dr. Sture A. M. Johnson of Madison was the guest speaker at the December 1 meeting of the Dodge County Medical Society, held at St. Joseph's Hospital in Beaver Dam. Doctor Johnson, who is professor of dermatology at the University of Wisconsin Medical School, spoke on "Common Dermatological Problems in General Practice." His talk was illustrated with kodachrome slides.

Fond du Lac

The Hotel Retlaw in Fond du Lac was the meeting place of the Fond du Lac County Medical Society on December 1. Dr. Howard M. Odel, a member of the staff of Mayo Clinic, Rochester, Minn., was the guest speaker, presenting a paper on the "Nature and Management of Acute Renal Failure (Lower Nephron Syndrome)."

Green Lake—Waushara

R. S. BEATTY

"X-Rays and Their Interpretation" was the title of a paper presented by *Dr. R. S. Beatty* of Oshkosh at a meeting of the Green Lake–Waushara County Medical Society at the Hotel Whiting in Berlin on December 22. At the business meeting, a fee schedule for county relief cases was discussed, and a committee consisting of *Drs. R. C. Darby*, Wautoma, *H. C. Koch*, Berlin, and *R. S. Pelton*, Markesan, was appointed to draw up a proposed schedule. Election of officers for 1950 resulted in the following physicians being named to office: *Drs. L. J. Seward*, Berlin, president; *A. A. Beck*, Wautoma, vice–president; *R. S. Pelton*, Markesan, secretary–treasurer; *Grant Stone*, Berlin, delegate; and *H. C. Koch*, Berlin, alternate delegate.

Jefferson

Dr. L. W. Nowack of Watertown was named president of the Jefferson County Medical Society at its business meeting on December 15. The meeting was held at St. Coletta Guest House in Jefferson. Officers who will serve with Doctor Nowack are *Dr. E. A. Schoenecker*, Lake Mills, vice-president; *Dr. R. W. Quandt*, Jefferson, secretary-treasurer; *Dr. F. H. Zimmerman*, Watertown, censor; *Dr. C. J. Garding*, Jefferson, delegate, and *Dr. F. Gruesen*, Fort Atkinson, alternate delegate. Doctors Schoenecker and *A. A. Busse*, Jefferson, will be in charge of public relief.

The November meeting of the Society was held at the Blackhawk Hotel in Fort Atkinson on November 17. *Dr. Vincent Koch* of Janesville, the guest speaker, discussed "Mistaking Other Diseases for Coronary Disease."

Kenosha

Dr. Edwin J. DeCosta, Chicago, spoke before a meeting of the Kenosha County Medical Society at the Elks Club in Kenosha on January 12. Doctor DeCosta, a member of the staff of Northwestern University Medical School, discussed "Hysterectomy: Vaginal or Abdominal." At the business meeting the Society endorsed the drive of the Wisconsin Heart Association.

Election of officers for the organization took place at a meeting at the Elks Club in Kenosha on December 1. Named to head the organization was *Dr. George Schulte; Dr. Richard Ashley* is president-elect; *Dr. H. A. Binnie*, secretary-treasurer; *Dr. C. F. Ulrich*, chairman of the board of censors; *Drs. David Goldstein* and *Ralph LaMacchia*, delegates; and *Dr. Leif Lokvam*, alternate delegate. All are from Kenosha.

La Crosse

Dr. George E. Skemp has been elected president of La Crosse County Medical Society for the coming year; *Dr. T. E. Gundersen* will serve as vice-president; and *Dr. P. V. Hulick* will be the secretary-treasurer. Censors appointed for 1950 include *Drs. J. C. Fox, Robert Gilbert*, and *Paul Gatterdam*. All officers are from La Crosse.

Marinette

The Riverside Country Club at Marinette was the meeting place for members of the Marinette County Medical Society on December 14. Election of officers was held, at which *Dr. James O. Zeratsky* of Marinette was named president; *Dr. Harvey Jorgenson*, vice-president; *Dr. R. J. Rogers*, Marinette, secretary-treasurer; *Dr. K. G. Pinegar*, delegate; *Dr. C. E. Koepp*, alternate delegate; and *Dr. G. R. Duer*, censor. *Dr. Sture A. M. Johnson*, professor of dermatology at the University of Wisconsin Medical School, Madison, was the guest speaker, discussing "Dermatological Problems in General Practice."

Marathon

Dr. Albert H. Stahmer, Wausau, was installed as president of the Marathon County Medical Society when the group met in the Wausau Club on December 6. *Dr. Clifford E. Kampine*, Marathon, was named president-elect of the Society, and *Dr. D. M. Green*, Wausau, was reelected secretary-treasurer. *Dr. J. K. Trumbo* will represent the group as delegate to the State Medical Society, and *Dr. George H. Stevens* will act as his alternate delegate. Both are from Wausau.

Oneida—Vilas

Officers of the Oneida-Vilas County Medical Society have been announced as follows:

Dr. Warner S. Bump, Rhinelander—President

Dr. Warren K. Simmons, Rhinelander—Vice-President

Dr. Walter Larrabee, Rhinelander—Secretary-Treasurer

Dr. I. E. Schiek, Sr., Rhinelander—Delegate

Dr. R. A. Oldfield, Eagle River—Alternate Delegate

Outagamie

Election of officers of the Outagamie County Medical Society on December 15 resulted in the following physicians being selected: *Dr. Stephen Konz*, president; *Dr. J. P. Skibba*, vice-president; *Dr. W. E. F. Mielke*, alternate delegate. All are from Appleton.

Pierce—St. Croix

Following a dinner at the Terrace in Somerset, members of the Pierce-St. Croix County Medical Society gathered at the Holy Family Hospital in New Richmond on December 20 to hear a talk by Dr. P. Hauser of St. Paul. His subject was "Dislocation, with Treatment." At the election of officers, which followed, *Dr. A. R. Aanes* of Ellsworth was chosen president; *Dr. Douglas Campbell*, New Richmond, vice-president; *Dr. C. E. McJilton*, River Falls, secretary-treasurer and delegate; and *Dr. Hoyt Epley*, New Richmond, alternate delegate.

Portage

Dr. Frank Iber of Stevens Point will head the Portage County Medical Society during 1950, as the result of an election held at a meeting of the group on December 13. Serving with Doctor Iber will be the following Stevens Point physicians: *Dr. E. E. Kidder*, vice-president and delegate; *Dr. H. A. Anderson*, secretary-treasurer; *Dr. J. A. Litzow*, censor; and *Dr. F. E. Gehin*, alternate delegate.

At the November meeting of the group, held at the Hotel Whiting in Stevens Point, *Dr. Francis F. Rosenbaum* of Milwaukee was the guest speaker. Doctor Rosenbaum, assistant professor of medicine at Marquette University School of Medicine, discussed the uses and abuses of the electrocardiogram.

Racine

Installed as president of the Racine County Medical Society on December 14 was *Dr. Beatrice O. Jones*, the first woman to serve as president of a county medical society in Wisconsin. She succeeds *Dr. Herbert G. Brehm*. The meeting took place at the Racine Country Club, where Doctor Jones was hostess to the Society at a pre-ceremony dinner. Other officers installed were *Dr. John Albino*, vice-president, and *Dr. Joseph Postorino*, secretary–treasurer. Wives of Racine County physicians were guests at the meeting.

Richland

A Madison urologist, *Dr. Palmer Kundert*, was the guest of the Richland County Medical Society on December 13, discussing problems in urology. Election of officers was held during the business session, with the following results: *Dr. R. J. Borgerson*, Richland Center, president; *Dr. Joseph Meboe*, Viola, vice-president; and *Dr. Gideon Benson*, Richland Center, secretary-treasurer. *Dr. Dayton Hinke*, and *Dr. R. E. Housner*, both of Richland Center, will serve as delegate and alternate respectively.

Shawano

Members of the Shawano County Medical Society named the following physicians to positions at their December election: *Dr. E. E. McCandless*, Wittenberg, president; *Dr. D. S. Arvold*, Shawano, vice-president; *Dr. F. W. Henke*, Shawano, secretary; *Dr. A. A. Cantwell*, Shawano, delegate; and Doctor McCandless, alternate delegate.

Walworth

When the Walworth County Medical Society met at the Colonial Hotel in Delavan on December 15, officers were elected for the coming year. *Dr. J. F. Bennett* of Burlington will serve as president; *Dr. R. S. Galgano* of Delavan was named vice-president; *Dr. M. J. Ciccantelli*, East Troy, was elected secretary-treasurer; and *Drs. E. D. Sorenson*, Elkhorn, and *H. J. Kenney*, Delavan will serve as delegate and alternate delegate, respectively.

Washington—Ozaukee

Dr. A. H. Barr of Port Washington will head the Washington–Ozaukee County Medical Society during 1950, as the result of an election held at the Republican Hotel in Kewaskum on November 14. Officers serving with Doctor Barr will be *Dr. E. C. Quackenbush*, Hartford, vice-president; *Dr. R. H. Driessel*, West Bend, secretary-treasurer; *Dr. F. I. Bush*, West Bend, delegate; *Dr. T. D. Elbe*, Thiensville, alternate delegate; and *Dr. R. S. Fisher*, Allenton, censor. Doctor Elbe reported on the October 1949 meeting of the House of Delegates of the State Medical Society, and *Dr. P. M. Kauth*, West Bend, showed colored pictures and discussed his recent trip to Alaska. The meeting was preceded by a dinner, with members of the Auxiliary to the organization as guests.

Trempealeau—Jackson—Buffalo

Three La Crosse physicians were guest speakers at the December 15 meeting of the Trempealeau–Jackson–Buffalo County Medical Society, held at the Fountain Hotel in Fountain City. *Drs. Joseph F. Egan* and *Peter V. Hulick* presented a symposium on "Carcinoma of the Cervix." *Dr. James C. Fox*, councilor from the Seventh District, discussed "What the Profession Has to Face in the Future." Officers elected to serve during 1950 are as follows: president, *Dr. F. J. Gillette*, Mondovi; president-elect, *Dr. S. W. Simonson*, Whitehall; secretary–treasurer, *Dr. R. L. Alvarez*, Galesville; delegates, *Dr. H. A. Jegi*, Galesville; and alternate delegate, *Dr. F. C. Skemp*, Fountain City.

Meeting in Whitehall on November 17, members of the Society heard a discussion of "Physiological Psychiatry," by *Dr. E. O. Niver* of Eau Claire. At the business session, the three resolutions adopted by the House of Delegates of the State Medical Society at its meeting in October 1949 were approved unanimously, and plans were formulated to carry out the program.

Waukesha

Members of the Waukesha County Medical Society and their wives were guests of Rogers Memorial Sanitarium, Oconomowoc, at a buffet supper presided over by *Dr.* and Mrs. *James C. Hassall* on December 7. Election of officers took place, *Dr. John D. Wilkinson* of Oconomowoc being named president of the group for 1950. *Dr. L. C. Olsen* of Delafield was elected vice-president; *Dr. F. L. Grover*, Hartland, secretary–treasurer; *Dr. J. C. Frick*, Waukesha, censor; *Dr. E. C. Van Valin*, Sussex, delegate; and *Dr. R. H. Schmidt, Jr.*, Statesan, alternate delegate.

Winnebago

Dr. John A. Schindler, Monroe, was the guest speaker at the December 1 meeting of the Winnebago County Medical Society, held at the Hotel Menasha in Menasha. Doctor Schindler discussed psychosomatic medicine, pointing out the need for thorough physical examinations and stressing that a doctor must be friendly with a patient in order to establish confidence. Election of officers resulted in the following men being named to positions: *Dr. Marvin Steen*, Oshkosh, president; *Dr. R. A. Jensen*, Menasha, vice-president; *Dr. John R. Nebel*, Menasha, delegate; and *Dr. G. R. Anderson*, Neenah, alternate delegate. The nominating committee included *Dr. J. P. Canavan*, Neenah, *George Forkin*, Menasha and *A. G. Koehler*, Oshkosh. *Dr. B. J. Hughes* of Winnebago reported on the North Central Medical Conference which he has recently attended.

The Bettman Archive

The nausea, vomiting and dizziness of motion sickness may be prevented or relieved, in a high percentage of cases, with Dramamine* (brand of dimenhydrinate).

DRAMAMINE for the Prevention and Treatment of Motion Sickness.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Trademark of G. D. Searle & Co., Chicago 80, Illinois

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

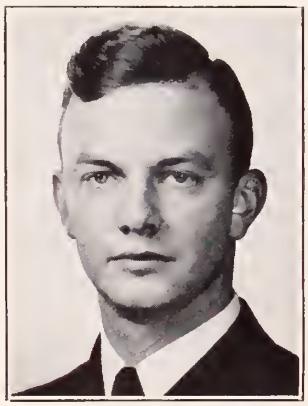
News Items and Personals

Monroe Physician Wins National Renown for Suggestions on Happy Living

Nationally acclaimed recently for his advice on "How to Live a Hundred Years Happily" was *Dr. John A. Schindler*, a staff member of the Monroe Clinic in Monroe. The talk was presented before a Farm and Home Week audience last February at the University of Wisconsin and was broadcast from the four stations of the State Radio Council FM network. Since that time, the address has been rebroadcast from numerous stations in all parts of the country, reprinted in many publications, and condensed in the December issues of the *Reader's Digest* and *Rotarian*. Doctor Schindler has been approached by several book publishers and a national speaker's bureau and was acclaimed by *Pathfinder* as a "phenomenon rare in radio, a real 'natural'." The doctor's suggestions for living happily were condensed in the following eight points: 1. Quit looking for a knock in your human motor. 2. Learn to like to work. 3. Learn to have a hobby. 4. Learn to like people. 5. Learn to be satisfied. 6. Learn to accept adversity. 7. Learn to say the cheerful, humorous thing. 8. Learn to meet your problems with decision.

The doctor, a graduate of Washington University School of Medicine, St. Louis, specializes in internal medicine.

Marsh Clinic, Shawano, Has New Associate



J. W. CHRISTOFFERSON

Dr. J. W. Christofferson, formerly of Marshfield, on January 1 became associated in practice with *Drs. H. C. Marsh* and *F. W. Henke* in the Marsh Clinic at Shawano. Doctor Christofferson, a native of Waupaca, graduated from Marquette University School of Medicine and interned at St. Joseph's Hospital in Milwaukee. Recently he completed a three and a half year residency in internal medicine and obstetrics at the Marshfield Clinic in Marshfield.

State Physicians Certified by American Board of Anesthesiology

Drs. James W. Bookhamer of Milwaukee and *Robert M. Wylde* of Madison were among a group of physicians recently certified as diplomates by the American Board of Anesthesiology.

At the annual meeting of the American Society of Anesthesiologists in December in New York, *Dr. Richard Foregger* of Milwaukee acted as delegate from the Wisconsin section of the organization. Dr. R. Anthony Tella of Milwaukee was the alternate delegate.

Dr. A. M. Hutter Addresses Chairmen of Heart Campaign

Dr. A. M. Hutter, Fond du Lac, president of the Wisconsin Heart Association, was one of the principal speakers at an institute for campaign chairmen and division leaders in eastern and northeastern Wisconsin, held in Green Bay on January 14. Doctor Hutter's talk was entitled "The 1950 Heart Program for Wisconsin."

Dr. R. H. Evers Becomes Superintendent of Rocky Knoll Sanatorium

Dr. Raymond Evers, a member of the staff of the Lakeview Sanatorium, Madison, was recently named medical director and administrator of the Rocky Knoll Sanatorium, Plymouth. He will begin his duties on March 1, succeeding *Dr. Chester S. Koop*, director of the institution since 1947. Doctor Evers, a graduate of the University of Illinois College of Medicine, was on the staff of the Healthwin Hospital, South Bend, Ind., before joining the staff of the Lakeview Sanatorium in 1946.

Doctor Koop will become director of the Genessee Sanatorium in Flint, Mich.

Bellin Memorial Hospital Staff Elects Officers

Dr. Max Grossman, Green Bay, was recently named president and chief of staff of the Bellin Memorial Hospital, Green Bay, for 1950. He succeeds *Dr. W. J. Troup. Dr. W. W. Ford*, Green Bay, will serve as vice-president, and *Dr. G. B. Merline*, De Pere, as secretary.

Physicians Attend Postgraduate Courses

Dr. J. P. Semmens, Waupun, and *Drs. E. C. Hoyer* and *A. B. Kores*, both of Beaver Dam, recently attended a three day course on cardiovascular diseases at the University of Minnesota Center for Continuation Study.

Dr. J. J. Rouse, Reedsburg, in December completed two courses at the Cook County Graduate School of Medicine, Chicago. Beginning on October 1, he spent two days each week at the Chicago school, during which he took courses in general surgery and gynecologic surgery.

Dr. Charles A. Vedder, Marshfield was among the 86 doctors who attended the University of Minnesota

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continuation course in traumatic and pediatric surgery November 10 through 12. The course was presented at the Center for Continuation Study.

Wisconsin Doctors Participate in National Allergists Meeting

Dr. Harry R. Weil, Milwaukee, presided at the morning session on the opening day of the annual meeting of the American College of Allergists in St. Louis on January 16. *Dr. Herman A. Heise*, also of Milwaukee, on that day presented a paper entitled "Meterological Factors in the Distribution of Pollen and Molds." On the following day, *Dr. Stephan Epstein* of Marshfield opened the discussion of a paper by Dr. B. M. Zussman, Memphis, Tenn., entitled "Severe Serum Sickness Type of Reaction-Failure of Anti-Histamine Therapy." Doctor Epstein also directed a panel on "Allergies of the Skin."

International College of Surgeons Names Fellows and Associate Fellows

According to a recent announcement from the International College of Surgeons, the following surgeons from Wisconsin were made Fellows and Associate Fellows in the United States Chapter of the International College of Surgeons at the convocation ceremonies held during the fourteenth annual assembly of the College in Atlantic City, N. J., November 7–11:

Certified Fellows

William E. Clark, M. D., Oshkosh
Ernest W. Miller, M. D., Milwaukee
Joseph R. Stone, M. D., Milwaukee
Dexter H. Witte, M. D., Milwaukee

Advanced to Rank of Certified Fellow:

N. E. Bear, M. D., Monroe
E. O. Gertenbach, M. D., Milwaukee
Frank B. Sazama, M. D., Chippewa Falls
S. E. Williams, M. D., Chippewa Falls

Associates:

O. F. Foseid, M. D., Menasha
Reginald H. Jackson, Jr., Madison

Kenosha Pediatrician Reenters Military Service

Dr. Paul Herzog, pediatrician at Kenosha since 1940, reentered military service early this year. He is located at the Station Hospital of the Army Air Base at Las Vegas, Nev. Doctor Herzog served in the Army Medical Corps from 1943 to 1945, during which time he was certified by the American Board of Pediatrics.

Dr. J. W. McRoberts Elected President of Sheboygan Hospital Staff

J. W. McROBERTS

At a luncheon meeting combining a business meeting with a Christmas party on December 20, *Dr. J. W. McRoberts*, Sheboygan, was named president of the Sheboygan Memorial Hospital staff. *Dr. Ludwig Gruenewald* was elected vice-president, and *Dr. F. A. Nause*, secretary–treasurer. *Drs. C. A. Squire* and *W. H. Neumann* were made members of the honorary staff.

Fort Atkinson Names Physician "Outstanding Young Man of the Year"

Dr. James Russell, Fort Atkinson, was named the city's "outstanding young man of the year" on January 19 and presented a distinguished service award by the Junior Chamber of Commerce. A native of Racine, Doctor Russell was graduated from the University of Wisconsin Medical School in 1946. Since his internship he has been in practice in Fort Atkinson.

Dr. Elizabeth Henning Addresses Council of Social Agencies

Dr. Elizabeth Henning, director of the Winnebago County Child Guidance Center, spoke on the services and program of the Center at a luncheon meeting of the Council of Social Agencies on December 20 at the Valley Inn at Neenah. The doctor, a graduate of Northwestern University Medical School, is a practicing psychiatrist at Neenah in addition to her work at the Guidance Center. The Center has been in existence for six years, and cooperates with school leaders, parents, local physicians and social agencies in solving emotional adjustment problems of children.

Marinette Hospital Staff Elects Officers

Dr. J. V. May was installed as president of the medical staff of the Marinette General Hospital at a meeting on January 11. Other officers are *Drs. G. R. Duer*, vice–president, and J. N. Dewane, Maribel, secretary–treasurer. *Dr. John M. Bell*, Peshtigo, retiring president, presented Doctor May with a gavel in memory of the late *Dr. J. W. Boren*. The gavel bears the following inscription on a metal band: "Marinette General Hospital Staff Gavel—In Memory of J. William Boren, M. D. Made by J. Eastman from maple grown on the grounds. Presented by the retiring president, John M. Bell."

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. H. E. Kasten Retires as Scout Chief of Stateline Council

H. E. KASTEN

Following fourteen years as president of the State Line Council of Boy Scouts and twenty-eight years in scouting work, *Dr. H. E. Kasten*, Beloit, retired from his position at the annual meeting of the organization held at the Traver Hotel in Lake Geneva on January 16. In his farewell address, Doctor Kasten declared that "Christian citizenship" as exemplified in the ideals of scouting must be built on the foundation of the "American heritage," and he urged the leaders to fight the infiltration of foreign "isms" and a drift of the American people to a socialized welfare state.

The following resolution was spread upon the minutes of the meeting:

"In recognition of 27 years of loyal service to Scouting, including 14 years as our president, the State Line Council, Boy Scouts of America, extends our thanks, our gratitude and our esteem to Dr. Harry Kasten, who tenders his resignation as our Council president at this 29th annual meeting. Dr. Kasten's resignation marks the end of a memorable era in Scouting. And it likewise marks the beginning of a memorable era for all of us.

"His leadership, and the support he has inspired, have made possible our great performance in the past, and our great promise for the future. Actually, this leadership combined with his length of service in Scouts sets an example that is rare even in Scouting Nationally. His contribution is not only unique, but praiseworthy beyond words.

"Our regrets because of his resignation are tempered by the fact that he will still be active in Scouting. Thus we will benefit from his steadfastness and his experience in the years to come."

Doctor Kasten serves as Councilor from the Third District of the State Medical Society.

Dr. J. W. MacGregor Addresses Portage Group

Dr. James W. MacGregor, Portage physician, spoke before a meeting of the Better Halfs Club of the Bethlehem Lutheran Church, Portage, on January 15. His subject was "Being a Good Parent." Doctor MacGregor is active in the educational field, being a member and former president of the Portage Board of Education.

Dr. John Talbot Begins Residency at Madison Hospital

Dr. John Talbot, practitioner at Wonewoc since 1946, recently began a three year residency in internal medicine at the State of Wisconsin General Hospital. The doctor, a graduate of the University of Wisconsin Medical School, entered the Army Medical Corps in 1940, and began his practice in Wonewoc shortly after his discharge in 1946.

Brodhead Practitioner Returns to Chicago

Dr. F. D. Swan, who has practiced at Brodhead since 1946, recently closed his practice in that community to begin a residency at Augustana Hospital in Chicago. A graduate of Loyola University School of Medicine, the doctor took postgraduate courses at the University of Chicago and at Cook County Graduate School of Medicine before beginning practice in Brodhead.

Janesville Physician Discusses Rock County Survey at National Meeting

Material based on a survey of 1,000 cases in Rock County was presented by *Dr. T. J. Snodgrass*, Janesville, before a meeting of the Western Surgical Association in Santa Barbara, Calif., on December 1. The paper, entitled "Gall Bladder Surgery; A Study of Results of Surgical Treatment in Rock County, Wisconsin," was written by Doctors Snodgrass and *Wayne A. Munn* of Janesville and *Thomas H. Flarity* of Beloit. In 756 of the 1,000 cases, the immediate results were presented, while the remaining 329 cases had been followed up over a long period.

This is the second paper concerning a survey in Rock County which has been given before a national group, the first one having been concerned with results in 1,200 cases of hernia.

Dr. Edward Jarvis Associates With Madison Physician

Now associated in the practice of medicine with *Dr. C. A. Fosmark* of Madison is *Dr. Edward Jarvis*, formerly of Milwaukee. Doctor Jarvis, a graduate of Marquette University School of Medicine, interned at the Jackson, Mich., City Hosital. He practiced in Hillsboro from 1942 to 1945, returning to Marquette at that time to become an instructor of surgical anatomy and clinical surgery while training in general surgery at the Milwaukee County Hospital.

University of Wisconsin Receives Money to Fight Cancer

A $30,000 gift from the Alexander and Margaret Stewart trust was accepted on January 14 by the Board of Regents of the University of Wisconsin for cancer research at McArdle Memorial Institute. Alexander Stewart was prominent in pioneer lumbering activities in the Wausau area, and his daughter Margaret Stewart lived in Wisconsin for many years before moving to Washington, D. C. At her death in 1946 she directed that the income from her entire estate be used to fight cancer.

Dr. H. C. Johnston Named to Wisconsin General Hospital Staff

The appointment of Dr. Herbert C. Johnston as assistant superintendent of the State of Wisconsin General Hospital was recently approved by the University Board of Regents. The Board met in Milwaukee on December 17. Doctor Johnston, a 1937 graduate of McGill University Faculty of Medicine, Montreal, Canada, interned at Montreal General Hospital and served one year as a resident in metabolic diseases. Following his discharge from Canadian military service in 1946, he has been associated with the Canadian Department of Veterans Affairs.

Madison General Hospital Elects Staff Officers

Dr. H. L. Greene was reelected chief of staff of the Madison General Hospital at a meeting on December 28. Other officers include *Dr. N. A. Hill*, vice-president; *Dr. Palmer R. Kundert*, secretary-treasurer; *Dr. John K. Curtis*, chief of medical service; *Dr. J. P. Malec*, chief of surgical service; and *Dr. Thomas A. Leonard*, chief of obstetric service.

Thirty Physicians Attend Graduate Course in Medicine

A graduate course in "Biological and Physiological Approaches to Internal Medicine," given at the University of Wisconsin Medical School the first week in December, was attended by thirty Wisconsin physicians. The course was co-sponsored by the University of Wisconsin Medical School and the American College of Physicians. Visiting faculty members for the session included Drs. J. H. Bollman, chairman of the division of experimental medicine, Mayo Clinic, Rochester, Minn.; Arthur J. Patek, Jr., Welfare Hospital for Children, Welfare Island, N. Y.; George W. Wright, Trudeau Foundation, Saranac Lake, N. Y.; Herbert C. Maier, Lenox Hill Hospital and assistant in surgery, Columbia College of Physicians and Surgeons, New York; Richard V. Ebert, University of Minnesota Medical School, Minneapolis; *Francis D. Murphy*, head of the department of medicine, Marquette University School of Medicine; *Armand J. Quick*, professor of biochemistry, Marquette University School of Medicine; and C. Phillip Miller, professor of medicine, University of Chicago School of Medicine.

Dr. E. E. Eckstam Receives Degree in Surgery

Dr. Eugene E. Eckstam, Madison, recently received a master of science degree in surgery from the University of Minnesota Medical School. The doctor is a 1943 graduate of the University of Wisconsin Medical School.

SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

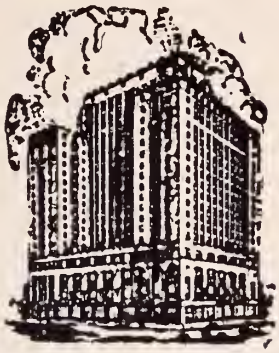
Members of the Columbia–Marquette–Adams County Medical Society gathered for a meeting at the Divine Savior Hospital in Portage on November 21. Two members presented papers, *Dr. James W. MacGregor*, Portage, speaking on "Tropical Diseases Encountered in Wisconsin;" and *Dr. C. F. Broderick* of Wisconsin Dells discussing "Recent Therapeutic Advances."

Rock

Meeting at the Cozy Inn in Janesville on December 27, members of the Rock County Medical Society heard talks by *Dr. W. D. Stovall* and Mr. C. H. Crownhart, both of Madison. Doctor Stovall, director of the State Laboratory of Hygiene and a past president of the State Medical Society, pointed out the "Need for Physicians to Assume Leadership in Each Community in Public Health Projects." Mr. Crownhart, secretary of the State Medical Society, spoke on the activities of State Medical Society committees.

Sauk

The Sauk County Medical Society met at Baraboo on December 13 to elect the following officers: president, *Dr. M. F. Huth*, Baraboo; vice-president, *Dr. K. D. Hannan*, Baraboo; secretary–treasurer, *Dr. B. E. McGonigle*, Baraboo; delegate, *Dr. J. F. Moon*, Baraboo; alternate delegate, *Dr. J. J. Rouse*, Reedsburg; and censor, *Dr. F. E. Tryon*, Baraboo. Guest speakers at the meeting were two faculty members from the University of Wisconsin Medical School: *Dr. Robert C. Parkin*, coordinator of graduate med-



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Basic Principles in General Surgery, Two Weeks, starting April 3.
Personal Course in General Surgery, Two Weeks, starting April 17.
Surgery of Colon & Rectum, One Week, starting March 6, April 10.
Esophageal Surgery, One Week, starting June 5.
Breast & Thyroid Surgery, One Week, starting June 26.
Thoracic Surgery, One Week, starting June 12.
Gallbladder Surgery, Ten Hours, starting April 24.
Fractures & Traumatic Surgery, Two Weeks, starting March 20.
GYNECOLOGY—Intensive Course, Two Weeks, starting February 20, March 20.
Vaginal Approach to Pelvic Surgery, One Week, starting March 6.
OBSTETRICS—Intensive Course, Two Weeks, starting March 6, April 3.
PEDIATRICS—Intensive Course, Two Weeks, starting April 3.
Personal Course in Cerebral Palsy, Two Weeks, starting July 31.
MEDICINE—Intensive General Course, Two Weeks, starting April 24.
Electrocardiography & Heart Disease, Four Weeks, starting March 13.
Hematology, One Week, starting May 8.
Gastro-Enterology, Two Weeks, starting May 15.
Liver & Biliary Diseases, One Week, starting June 5.
Gastroscopy, Two Weeks, starting March 6, May 15.
DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting April 17.
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ical education, and *Dr. R. E. Campbell*, professor of obstetrics and gynecology, who discussed "Pelvimetry."

TWELFTH DISTRICT NEWS

Milwaukee Presents Public Program on Arthritis

About 500 persons interested in arthritis met at the auditorium of the Marquette University School of Medicine on November 10, to hear a discussion of that subject presented under the auspices of the Wisconsin Rheumatism Association and the Wisconsin Chapter of the American Rheumatism Foundation. The program consisted of a question and answer panel period in which the following physicians took part: *Drs. Ray Piaskoski, Millard Tufts, Milton C. Borman, J. F. Wyman, Maurice Hardgrove*, and M. Meyers of Milwaukee; *A. W. Bryan* of Madison; and *C. C. Edmondson* of Waukesha, all members of the Wisconsin Rheumatism Association. The speaker of the evening was Dr. Robert M. Stecher of Cleveland, past president of the American Rheumatism Association. Most of those attending the meeting were persons afflicted with some form of arthritis.

Dr. F. A. Stratton Named Emeritus Professor at Marquette

Dr. Frederick A. Stratton, a member of the faculty of Marquette University School of Medicine for forty-three years, recently retired from his position as clinical professor and director of the department of general surgery. *Dr. John S. Hirschboeck*, dean, has announced that Doctor Stratton will now hold the honorary position of professor emeritus.

The doctor, a 1903 graduate of the Wisconsin College of Physicians and Surgeons, joined the university faculty that same year, was appointed professor of surgery in 1923, and was named director of clinics in the division of general surgery in 1929. In 1934 he was named director of the department of surgery. The doctor will now devote full time to his medical practice.

Milwaukee Doctor Presents Paper at A. M. A. Session

A paper entitled "Fever Convulsions in Children" was presented before the pediatric section of the A.M.A. clinical session on December 8 by *Dr. M. G. Peterman* of Milwaukee. The meeting was held in Washington, D. C.

Dr. L. J. Paquette Assumes Practice of Late Milwaukee Physician

Dr. L. J. Paquette, who was associated with the late *Dr. R. W. Roethke* of Milwaukee, has now taken over the practice of Doctor Roethke and will continue his work in obstetrics and gynecology. Doctor Paquette, a graduate of Marquette University School of Medicine, interned at St. Mary's Hospital, Milwaukee. Following four years of service in the United States Navy, the doctor returned to his special studies in obstetrics and gynecology at St. Mary's Hospital. In June 1949 he joined Doctor Roethke in practice.

Child Care Center Memorial to Dr. Katharine H. Baird

In memory of the late *Dr. Katharine H. Baird*, who served as medical advisor and board member of the Child Care Center, Milwaukee, the South Side Unit will be named the Katharine H. Baird Center. The child care centers offer care to pre-school age children who cannot be satisfactorily cared for at home during the day. *Dr. Karl Beck*, successor to Doctor Baird as medical advisor, described her as a "vivacious, sympathetic champion of underprivileged children . . . a person who had done more good works in her short life than most of us could do in two spans of life."

Dr. H. R. Foerster Elected to Honorary Position With British Society

Dr. Harry R. Foerster, Milwaukee dermatologist, was elected an honorary member of the Royal Society of Medicine, Section of Dermatology, on May 19, 1949, at London, England. Doctor Foerster serves as associate clinical professor of dermatology at Marquette University School of Medicine in addition to maintaining a private practice.

Dr. J. M. Lubitz Authorized to do Blood Tests For Marriage Licenses

Dr. Joseph M. Lubitz, Wood, was recently authorized as pathologist to do blood tests for marriage licenses, by the State Board of Health. Doctor Lubitz is chief of the laboratory service at the Veterans Administration Center, Wood.

SOCIETY PROCEEDINGS

Milwaukee

Installed as president the Medical Society of Milwaukee County at the Milwaukee Athletic Club on December 8 was *Dr. E. L. Bernhart*, who succeeded *Dr. Leander J. Van Hecke* to the position. Doctor Bernhart is also president-elect of the Wisconsin Chapter of the American Academy of General Practice and president of the medical staff of St. Mary's Hospital. *Dr. Maurice Hardgrove*, senior medical consultant at the Veterans Administration Hospital, Wood, was named president-elect. Officers who will serve with Doctor Bernhart are *Drs. Harold E. Cook*, secretary; *Robert W. Mann*, treasurer; *L. J. Van Hecke*, director and *Joseph Shaiken* and *A. J. Baumann*, censors. Delegates to the State Medical Society include *Drs. C. M. Echols, L. J. Schneeberger, J. V. Herzog, Frank E. Drew, Norbert Enzer, W. J. Houghton, Jerome W. Fons, Stanley*

Hollenbeck, M. C. Borman, and *M. J. Kuhn*. Their alternates will be *Drs. James G. Garland, Harry P. Maxwell, John D. Charles, Leonard J. Schwade, Joseph Shaiken, Paul J. Purtell, George S. Kilkenny, E. R. Daniels, H. N. Dricken*, and *Conde F. Conroy*.

Milwaukee Academy of Medicine

Meeting at the University Club of Milwaukee on December 20, members of the Milwaukee Academy of Medicine heard a talk by Dr. Cecil J. Watson, professor and head of the department of medicine at the University of Minnesota Medical School and chief of the medical service at the University of Minnesota Hospitals. Doctor Watson discussed "Diseases of the Liver." A special clinic was held the following morning at the Veterans Administration Hospital, Wood, for the "Diagnosis of Diseases of the Liver."

The annual dinner meeting of the Milwaukee Academy of Medicine was held at the University Club of Milwaukee on January 17. *Dr. William M. Jermain* was installed as president, succeeding *Dr. Harry Beckman*. Honorary memberships were conferred and essay contest awards were presented, following which Dr. William Boyd, professor of pathology and bacteriology at the University of Toronto, discussed "Education and Specialization in Medicine."

Milwaukee Neuro-Psychiatric Society

Drs. Francis J. Millen and *J. L. Garvey* presented papers before the meeting of the Milwaukee Neuro-Psychiatric Society at the University Club on January 18. Doctor Millen discussed "Electroencephalography," and Doctor Garvey spoke on "Pseudo-Hypoparathyroidism."

Milwaukee Oto-Ophthalmic Society

"Management of the Glaucoma Clinic" was the subject presented to the members of the Milwaukee Oto-Opthalmic Society on January 24 at the Milwaukee Athletic Club. The guest speaker was Dr. H. Isabelle McGarry, a member of the staff of the Illinois Eye and Ear Infirmary.

Medical Veterans of Milwaukee County

Dr. V. LaMar Baker, Milwaukee urologist, was recently named president-elect of the Medical Veterans of Milwaukee County. *Dr. I. J. Ricciardi*, Milwaukee, was installed as president of the organization. Other officers include *Dr. M. Alex Krembs*, secretary; and *Dr. Leonard S. Markson*, treasurer.

Milwaukee Metropolitan Section of American College of Chest Physicians

The Milwaukee Metropolitan Section of the American College of Chest Physicians met on November 25 at the Medford Hotel in Milwaukee. *Drs. Timothy R. Murphy* and *Armin R. Baier* spoke on "Pulmonary Function." This was followed by a round-table discussion.

SOCIETY RECORDS

New Members

A. M. MacKay, Madison.
R. C. Parkin, Madison.
P. H. Gutzler, River Falls.
Frank Hilpert, Racine.
E. S. Olson, Racine.
J. M. Moir, Sheboygan.
K. M. Keane, Sheboygan.
G. A. Dedeinsky, 5000 West Chambers Street, Milwaukee.
D. L. Taber, 230 West Madison Street, Milwaukee.
O. E. Ogilvie, Wood.
D. M. Rozran, 238 West Wisconsin Avenue, Milwaukee.
A. V. Pisciotta, 8700 West Wisconsin Avenue, Wauwatosa.
L. L. Kishner, 5429 South University Avenue, Chicago.
R. M. McCormack, 324 East Wisconsin Avenue, Milwaukee.
R. J. Mayer, Wood.
M. C. Wynes, 728 North Jefferson Street, Milwaukee.
S. S. Bederman, 908 N. 12th Street, Milwaukee.
J. P. Fetherston, Jr., 2218 North Third Street, Milwaukee.
W. W. Chandler, 7608 West State Street, Wauwatosa.
H. F. Avery, 721 North 17th Street, Milwaukee.
J. E. Abrams, Cudahy.
E. L. MacVicar, Jr., 411 East Mason Street, Milwaukee.
D. P. Babbitt, 2200 West Kilbourn Street, Milwaukee.
E. F. Schubert, 8844 West Wisconsin Avenue, Wauwatosa.
J. D. Silbar, 908 North 12th Street, Milwaukee.
F. J. Finn, Wood.
H. J. Kanin, Wood.
Joseph Efron, 8700 West Wisconsin Avenue, Wauwatosa.
H. S. Caskey, 1845 N. Fourth Street, Milwaukee.
Jules Chase, Wood.
H. A. Trangsrud, Wood.
T. A. Burns, Wood.
J. B. Baldi, 1935 W. Atkinson Avenue, Milwaukee.
M. S. Tverberg, Mauston.
R. E. Schlitter, Eau Claire.
A. A. Hovda, Tomah.
E. C. Jarvis, Madison.
I. J. Sarfatty, Madison.
R. H. Brodhead, Madison.
L. S. Kellogg, Oregon.
J. W. Doolittle, Madison.
W. M. Sencer, Madison.
Dorothy Betlach, Madison.
J. D. German, Clintonville.
C. W. Schmidt, Waterloo.
R. P. Bergwall, Hartland.
T. M. Haug, Rhinelander.

P. B. Savory, Minocqua.
R. M. La Macchia, Kenosha.
R. H. Wiley, Iola.
J. R. O'Connell, Wood.
J. S. Stehlin, 2200 W. Kilbourn Ave., Milwaukee.
M. W. Monroe, Wood.
P. H. Settlage, Madison.
F. E. Golden, Ashland.
E. L. Perry, La Crosse.
Milton Feig, Green Bay.
J. T. Garren, Kenosha.
Ann Cinelis, Sheboygan.
Mary Fetter, Sturgeon Bay.

Changes in Address

T. G. Malloy, Milwaukee, to Veterans Administration, Wood.

T. J. Pfeffer, Milwaukee, to Veterans Administration, Wood.

R. F. Swanson, Oak Park, Illinois, to MacCornack Clinic, Whitehall.

H. J. Holland, Mayville, to Mukwonago.

M. J. Bode, Wood, to Kenosha National Bank Building, Kenosha.

G. J. Hugo, Norwalk, Ohio, to 1700 South 60th Street, West Allis.

D. W. Calvy, Milwaukee, to 839 Glenview Avenue, Wauwatosa.

M. A. Cornwall, Baldwin, to St. Joseph Hospital, St. Paul, Minnesota.

B. S. Schaeffer, Bellwood, Illinois, to Milwaukee.

J. J. O'Toole, Watertown, to Harvard, Illinois.

H. H. Everett, Jr., Milwaukee, to Green Bay.

J. C. Lillie, Janesville, to Rochester, Minnesota.

P. M. Wilkinson, Wauwatosa, to 618 West La Belle Avenue, Oconomowoc.

R. E. Flood, Sparta, to 2320 North Lake Drive, Milwaukee.

Eleanora Fabry Jorgensen, Milwaukee, to 412 Main Street, Thorp.

P. B. Jorgensen, Milwaukee, to 412 Main Street, Thorp.

Helen S. Marshall, Statesan, to 17349 Beade Drive, N.E., Seattle, Washington.

L. L. Thompson, De Forest, to Argyle.

C. L. Rumph, South Milwaukee, to 1404 Lake Drive, South Milwaukee.

E. P. Huth, Wauwatosa, to 945 N. Twelfth Street, Milwaukee.

G. J. Roncke, Wood, to 1225 W. Mitchell Street, Milwaukee.

Lt. A. A. Tratar, Corona, California, to U. S. Naval Hospital, Long Beach, California.

Halbert Gulbrandsen, Viroqua, to V. A. Hospital, Fort Lyon, Colorado.

R. J. Rogers, Marinette, to Mayo Clinic, Rochester, Minnesota.

C. C. H. Cullander, Great Lakes, Illinois, to Worcester State Hospital, Worcester, Massachusetts.

BIRTH

A daughter to Dr. and Mrs. Philip Wilkinson, Milwaukee, on November 17

DEATHS

Dr. Arthur W. Boslough, Wausau physician since 1919, died at his home in that city on November 21, following a long illness. He was 68 years old.

Born at Paw Paw, Illinois, on December 18, 1880, the doctor received his degree in medicine from Rush Medical School in 1905. During World War I he served in the Army, and shortly therefater he established his practice in Wausau. He was a member of the staffs of St. Mary's and Memorial hospitals in that city.

Doctor Boslough was a member of the Marathon County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife and two daughters.

Dr. William B. Ford, 75, Milwaukee specialist in diseases of the heart and lungs, died at his home on December 1. He had retired from medical practice in August.

Born at Sparta on August 27, 1874, Doctor Ford received his M.D. degree from Rush Medical School, Chicago, in 1903. He established his first practice in Norwalk, moving to Milwaukee in 1912. For twenty-five years he served as assistant superintendent of the tuberculosis division of the Milwaukee Health Department, and for almost as long a period he was an associate professor of medicine at Marquette University School of Medicine. He was a member of the staffs of St. Joseph's, Deaconess, and Milwaukee hospitals. During World War I he was a first lieutenant in the Army Medical Corps.

The doctor was a member of the Milwaukee Academy of Medicine, the American College of Chest Physicians, the Wisconsin Heart Association, and the American Trudeau Society. He also held membership in the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife and three sons.

Dr. William E. Ground, Superior physician since 1891 and a past-president of the State Medical Society, died at a Superior hospital on November 29. His death ended what is believed to be the longest contemporary medical career in the nation. At the age of 88, he had practiced medicine for sixty-eight years.

The doctor was born at Spencer Owen, Indiana, on July 14, 1861. He attended Missouri Medical College, now Washington University School of Medicine, graduating in 1881. Following completion of his intership at St. John's Hospital, So. Louis, the doctor began his medical career at Linton, Ind. Later he practiced in Ohio, New York, and New Hampshire, locating in Superior in 1891. There he served as city

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health commissioner and was a member of the staffs of St. Mary's and St. Joseph's hospitals.

President of the State Medical Society in 1908, Doctor Ground was elected to life membership in the organization in 1944. He became a member of its Fifty Year Club in 1948. He was a past-president of the Douglas County Medical Society and a fellow in the American Medical Association.

A son survives.

Dr. E. O. McCarty, 66, physician at Chippewa Falls since 1922, died at his home in that city on November 27. He had retired from medical practice in 1946.

Born at Melrose on September 15, 1884, the doctor gained his medical degree at the University of Minnesota Medical School. Following his graduation in 1909, he established a practice at Knapp. In 1922 he moved to Chippewa Falls, where he practiced until several years ago, when ill health necessitated his retirement.

Doctor McCarty was a member of the Chippewa County Medical Society, the State Medical Society, and the American Medical Association.

His wife survives.

Dr. J. W. Boren, well known Marinette physician, died at a Marinette hospital on December 15. He was 60 years old.

A lifelong resident of Marinette, the doctor was born on December 28, 1888. He studied medicine at Northwestern University Medical School, graduating in 1912. Following internship at the Cook County Hospital, Chicago, he established his practice in Marinette in 1914. In 1936 he, with his brother, Dr. C. H. Boren, and a sister, founded the John E. Boren Clinic, named after their father. Doctor Boren was also instrumental in the establishment of the Marinette General Hospital in Marinette and was a member of the building committee. During World War I he served in the Army Medical Corps.

For many years the doctor was city health commissioner of Marinette. He served on the staffs of Marinette General Hospital and of St. Joseph's Hospital, Menominee, Mich. He was a member of the Marinette County Medical Society, the State Medical Society, the American Medical Association, and the American College of Surgeons.

Survivors include his wife, two sons, and two daughters.

Dr. Frank H. Russell, former health commissioner of West Allis, died at a hospital in Tomah on December 31. He was 75 years old.

The doctor was born at Fond du Lac on December 2, 1874. He received his degree in medicine from Northwestern University Medical School in 1902. During World War I he served with the Army Medical Corps, and in 1919 he located in Weyauwega. In 1929 he moved to West Allis to enter private practice, and in 1935 he was named health commissioner of that city. Following his retirement in 1942, he practiced for a brief period at Elkhart Lake.

Doctor Russell is survived by his wife, three daughters, and two sons.

Dr. Joseph H. Doyle, physician at Little Chute for fifty years, died at an Appleton hospital on January 5. He was 79 years old.

Doctor Doyle was born at Rantoul in Calumet County on June 24, 1870. He taught school before entering the Chicago College of Physicians and Surgeons, and in 1897 he received his medical degree from the Wisconsin College of Physicians and Surgeons, Milwaukee. That year he entered medical practice in Freedom, and a year later he moved to Little Chute.

A past-president of the Outagamie County Medical Society, Doctor Doyle was a life member of the State Medical Society and a member of the American Medical Association.

He is survived by his wife and a daughter.

Dr. Frank J. Hager, physician at Denmark for thirty-nine years, died at a Green Bay hospital on January 5. He was 67 years old.

Born in the town of New Denmark on November 20, 1882, the doctor taught school for a number of years before entering the field of medicine. He received his M. D. degree from Marquette University School of Medicine in 1911, and shortly thereafter, established his practice in Denmark. At various times he had been village health officer. During World War I he had served as a captain with the Army Medical Corps.

Doctor Hager was a member of the Brown-Kewaunee-Door County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife and two daughters.

ELLEN N. ATKINSON

Mrs. L. DeWitt Atkinson, assistant editor of The Wisconsin Medical Journal from 1944 to 1947, died at a Milwaukee hospital on December 21, following a brief illness. She was 31 years old.

A native of Madison, Mrs. Atkinson was the daughter of Mr. and Mrs. Edward T. Nesvig. She attended the University of Wisconsin and later became medical editor for the Jackson Clinic in that city. In 1944 she joined the staff of the State Medical Society, where she served as assistant editor of the Journal until 1947. At that time she moved to Milwaukee, where her husband serves as assistant secretary of the Wisconsin Pharmaceutical Association. She is survived by her husband, an infant daughter, her parents, and a brother.

Dr. Frank C. Binnewies, 83, who had practiced medicine in Janesville for more than forty years, died at his home in Orlando, Fla., on December 29. The doctor had resided in Florida since his retirement from medical practice about five years ago.

Doctor Binnewies was born in Harvard, Ill., on May 31, 1866. He attended the Chicago Homeopathic Medical College, Chicago, receiving his medical degree in 1900. Before locating at Janesville, where he specialized in treatment of the eye, ear, nose, and throat, Doctor Binnewies had practiced in Milton.

A life member of the State Medical Society, the doctor was a member of the Rock County Medical Society and the American Medical Association.

He is survived by his wife and a daughter.

NOTES ON CLINICAL PATHOLOGY

(Continued from page 143)

4. Maclay, E.: A suitable substrate for the determination of pancreatic lipase in serum and other body fluids, Am. J. M. Technol. 14:197 (July) 1948.
5. Musgrove, J. E.: Elevated serum amylase levels associated with perforated gastroduodenal lesions, Proc. Staff Meet., Mayo Clinic 25:8 (Jan. 4) 1950.
6. Myhre, J., and Nesbitt, S.: Pancreatitis in infectious mononucleosis 34:1671 (Dec.) 1949.
7. Somogyi, M.: Micromethods for the estimation of diastase, J. Biol. Chem. 125:399 (Sept.) 1938.
8. Wells, B. B.: Clinical Pathology; Application and Interpretation, Philadelphia, W. B. Saunders Company, 1950, pp. 152–154.

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Convention—
Mrs. B. I. Brindley, Madison

Some Winter Activities of the Auxiliary, 1950

Rock

Meeting at the Hotel Hilton in November at Beloit, the newly reorganized Rock County Auxiliary met for business and sociability. *Hygeia* was promoted for use as a Christmas gift. For entertainment, Mrs. Tracy Rossweiler, former instructor of drama at Beloit College, gave several humorous readings.

Dane

Mrs. E. F. Schneiders served as chairman of the hospitality committee when the Dane County Woman's Auxiliary met for its January meeting in the staff room of St. Mary's hospital. The program was a panel discussion on compulsory health insurance by five members of the League of Women Voters. The women presented both sides of the controversial question for the purpose of giving information only. Assisting Mrs. R. H. Ludden with serving were Mrs. John Van Gemert, Mrs. C. F. Sherman, Mrs. O. S. Orth, Mrs. John T. Sprague, and Mrs. Lester McGary.

A study group has been arranged, open to all Auxiliary members and friends, which will meet at the State Medical Society building. Mr. Earl Thayer, director of public information for the State Medical Society, will be present at this meeting.

Mrs. Peter Duehr, program chairman, added two new features to the December meeting; namely, a musical program, and a distinguished speaker. The meeting was held at the home of Mrs. Homer Carter. Selections were: a cello solo by Margery Carter, accompanied by her mother; Slavic Christmas carols sung by Phyllis Juster, daughter of Dr. and Mrs. Eugene Juster; and a short Christmas reading by Mrs. Walter Sullivan. Mrs. Robert Fitzgerald, Wauwatosa, was the guest of honor. Dessert and coffee were served by a committee composed of Mrs. D. L. Williams, assisted by Mrs. C. O. Vingom, Mrs. Albert Bryan, Mrs. L. E. Holmgren, Mrs. Ralph Campbell and Mrs. George Ewell.

Sheboygan

Meeting jointly for a 1 o'clock buffet luncheon at Power's Club Heidelberg restaurant, in Sheboygan, members of the Sheboygan County Dental auxiliary and the Sheboygan County Medical Auxiliary had the privilege of hearing Dr. Keith M. Keane, Madison psychiatrist, discuss the subject "Preventative Psychiatry."

After relating medical achievements in the prevention of various diseases Doctor Keane proceeded to speak on preventions in the field of psychiatry. In describing underlying factors which lead to psychiatric treatment, the speaker stressed the child-parent relationship as paramount in line of prevention. In applicable terms, he defined affection, praise, and consistency as preventative approaches to psychiatry. He listed neurotic conditions, get-well desires, personality of individuals, and duration of illnesses as determining factors in psychiatric treatments.

Hostesses for this joint meeting were Mrs. T. J. Gunther and Mrs. Homer H. Kohler of the Medical Auxiliary, and Mrs. Douglas Rablee and Mrs. Stanley E. Eichstaedt of the Dental Auxiliary.

Brown—Door—Kewaunee

The Medical Auxiliary to the Brown–Kewaunee–Door County Medical Society had its annual open meeting in December at the Woman's Club, Green Bay. Mrs. Robert Fitzgerald, Wauwatosa, of the state and national auxiliary spoke on "What Really is Socialized Medicine." After the program, guests were invited to attend a Christmas tea, planned by Mrs. George Skinners, assisted by Mmes. Warren Leaper, Robert Kispert, and members of the board. Mrs. Robert Burns is president; Mrs. Emil Nadeau, chairman of public relations; Mrs. Patrick Dockry, program; and Mrs. John Boersma, legislative chairman.

Milwaukee

A noteworthy news item comes from the December 6 *Milwaukee Journal:* "Two student nurses in Milwaukee hospitals have been awarded $250 scholarships by the woman's auxiliary to the Medical Society of Milwaukee County. Recipients are Joan Pope, 18, route 1, Waukesha, of the County General Hospital and Mary Campbell, 18, of 1119 W. Vine St., Misericordia hospital. The awards cover three years' tuition while in training."

CORRESPONDENCE

ASSOCIATED HOSPITAL SERVICE INC.
826 N. Plankinton Ave., Milwaukee 3, Wis.
January 30, 1950

My dear Dr. Truitt: Only the very heaviest pressure of work has prevented me from expressing to you my sincerest appreciation for your clear and forthright statement entitled "It Is Your Responsibility" which appeared in last month's issue of the *Wisconsin Medical Journal.*

Your statement, coming at this time, was particularly encouraging to me because only recently Ralph Weber and I had discussed the need and advisability of greater collaboration in the field of enrollment between the Blue Cross and Blue Shield plans on the one hand and members of the medical profession on the other.

It cannot be denied that if the best interests of the public, the medical profession and the hospitals are to be served, it can be done only by a vigorous stimulation of the public to enroll in the voluntary health plans; and, no single group can do more in that direction than your own profession. The amount of understanding and knowledge which the doctors of our state have about Blue Cross and Blue Shield and the amount of cooperation they are willing to give towards wider acceptance of these programs among their own patients can have a profound influence on the future of the plans and, of course, upon the best interests of society at large.

I am greatly heartened by your statement because I know that it will be read and pondered by the medical profession of our state and that it will elicit the sort of response which cannot help but result beneficially to Blue Cross and Blue Shield. With such cooperation I am convinced that as we enter our tenth anniversary year we can make 1950 one of our greatest years in enrollment in the health care plan, in service to our members, to the medical profession, to the hospitals, and to the public at large.

With every best wish, I remain

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Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: A young physician assistant in general practice in central Wisconsin. Hospital facilities available. Address replies to No. 276 in care of the Journal.

FOR SALE: Practice and office equipment in prosperous southern Wisconsin agricultural dairying section at Brodhead. Excellent hospital facilities nearby at Monroe. Reasonably priced. Only one other physician in active practice. Leaving to take residency. See Al Heuer at Brodhead or Dr. F. D. Swan, Augustana Hospital, 411 West Dickens Avenue, Chicago.

WANTED: General practitioner in a village of about 1,000. No competition. Office available. Prospects of a hospital within a year. Address replies to No. 258 in care of the Journal.

AVAILABLE: Very desirable county seat–summer resort location in central Wisconsin available immediately. Former physician deceased. Address replies to No. 275 in care of the Journal.

FOR SALE: Country practice in northwest Wisconsin. No competition. Modern residence, ideally located. Annual dairy income in territory. Nothing to buy but five bedroom residence, with office room, waiting room, and laboratory in residence. Separate parking and sidewalk to waiting room. Spacious lawn, foliage, and ideal residence. Young man can use extra rooms for hospital rooms. Selling reason: coronary thrombosis. Address replies to No. 243 in care of the Journal.

AVAILABLE: Excellent opening for young doctor in prosperous community in northwestern part of Wisconsin. Hospital facilities available. Possibilities of permanent position in clinic. Scandinavian preferred, though not necessary. If interested, write qualifications. Address replies to No. 282 in care of the Journal.

PHYSICIAN WANTED: Having recently purchased the Grant Community Hospital in Lancaster, I need an associate in general practice. Preferably someone with surgical training. Opening available January 1, 1950. H. W. Carey, M. D., Lancaster, Wisconsin.

FOR SALE: Ophthalmologist–otolaryngologist wishes to sell forty year old established practice located in an industrial area of Milwaukee. Doctor agrees to work with buyer until business is secure. Address replies to No. 283 in care of the Journal.

WANTED: Resident Physician. Large institution for mentally deficient located in nice residential section of thriving city of 140,000. Practice can be limited to general medical services, but there is opportunity for study in psychiatry with a certified psychiatrist on the staff. Also opportunity for experience in pediatrics and moderate amount of surgery. Good salary, liberal time off for week-ends, holidays, sick leaves and vacations with full pay. Full maintenance for man and wife (quarters not available for children at this time). Night work at a minimum. Moderate physical handicaps no bar to employment. Write Superintendent, Fort Wayne State School, Fort Wayne, Indiana.

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INTERNIST, age 34, married, desires association with group or established internist or surgeon. Three year approved residency. Board eligible in August. Address replies to No. 284 in care of the Journal.

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TERM EXPIRES 1951

H. E. Kasten_____Beloit

TERM EXPIRES 1952

Fourth District:
E. M. Dessloch_Prairie du Chien

TERM EXPIRES 1952

Fifth District:
A. H. Heidner_____West Bend

Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1950

Seventh District:
J. C. Fox_____La Crosse

Eighth District:
J. M. Bell_____Peshtigo

Ninth District:
H. H. Christofferson_____Colby

Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1951

Eleventh District:
V. E. Ekblad_____Superior

Twelfth District:
R. E. Galasinski____Milwaukee
T. J. Howard_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1952

D. F. Pierce____Hales Corners

TERM EXPIRES 1950

Thirteenth District:
J. D. Leahy_____Park Falls

TERM EXPIRES 1950

K. H. Doege_____Marshfield
(Past-President)
S. E. Gavin_____Fond du Lac
Chairman Emeritus

Delegates to American Medical Association

(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1950 James C. Sargent, Milwaukee, 1950 William D. Stovall, Madison, 1951

Alternates

L. O. Simenstad, Osceola, 1950 D. H. Witte, Milwaukee, 1950 D. J. Twohig, Fond du Lac, 1951

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The
MEDICAL FORUM

The Wisconsin Medical Journal February, 1950

NEW POSTGRADUATE EDUCATION PLAN PROPOSED FOR GP'S

STATE CHAMBER OPPOSES HR 6000

Madison, Feb. 14.—Extension of social security coverage to farmers and business and professional groups was recommended by the board of directors of the Wisconsin State Chamber of Commerce at a meeting in Milwaukee on Feb. 9.

At the same time, the board urged strong opposition to the program of permanent and total disability insurance being proposed in H. R. 6000. This program would, according to many authorities, open the door for socialized medicine.

Society Represented

The board's action was taken upon the recommendation of the social security committee of the Chamber of which Mr. C. H. Crownhart, secretary of the State Medical Society, is a member.

The extension of coverage was suggested in the belief that old age and survivors insurance should be established as a basic floor of protection for all gainfully employed.

Call for the Doctors?

Unification is working perfectly among the medical officers of the army, navy and air force, the surgeon general of the navy told an audience at Marquette University. He said that there has been nothing but harmony, cooperation and brotherly love among the doctors in the three services.

Wonderful!

In view of recent events, perhaps the best solution for the interservice friction that has been exhibited elsewhere is to appoint no one to the high command of the army, navy and air force, and to the joint chiefs of staff, who does not hold an M. D. degree.

—Milwaukee Journal, Oct. 15, 1949

State Medical Society Inspires "Circuit Rider" Lecture Tours

DR. W. S. BUMP

Madison, Jan. 21.—Nine statewide health organizations have taken the first step in evolving a coordinated system of postgraduate medical education for physicians that is termed "one of the most significant developments in medical education in Wisconsin in recent years."

The plan was initiated by the State Medical Society's Council on Scientific Work under the chairmanship of Dr. J. M. Freeman, Wausau. Actual implementation of the program is under the direction of the Coordinating Committee on Post-Graduate Education consisting of representatives of the nine health groups with Dr. W. S. Bump, Rhinelander, as chairman.

The coordinating committee proposes sending teams of two or three doctors on "one-night stands" to various parts of the state for discussions of scientific subjects that will virtually bring knowledge of new medical advances to the doctor's doorstep.

For example, a team of doctors from Marquette or Wisconsin medical school may hold a three hour session each Wednesday night for eight weeks at Eau Claire. The following eight week sessions may be held in Wausau, Green Bay, or other cities. Such a plan will not get under way until 1951 since the current post-graduate program is already scheduled.

Represented at the first meeting of the coordinating committee at the Society's headquarters on Jan. 21 were the State Board of Health, Dr. E. H. Jorris, Madison; University of Wisconsin Medical School, Dr. Robert Parkin, Madison; Marquette University School of Medicine, Dr. E. A. Bachhuber, Milwaukee; Wisconsin Heart Association, Dr. L. R. Schweiger, Milwaukee; National Foundation for Infantile

(Continued on page 3)

BLUE SHIELD PLANS COVER 13,000,000

Chicago, Jan. 30.—Seventy-nine Blue Shield plans in United States now cover a total of 13,140,000 members for surgical and medical expenses incident to illness, according to a report published recently by Associated Medical Care Plans, the national organization of Blue Shield programs.

The report lists Wisconsin with a total membership of 362,000 persons covered as of Sept. 30, 1949—Wisconsin Physicians Service with 141,000 and Surgical Care of Milwaukee with 220,000.

Wisconsin is reported to have 10.78 per cent of its population enrolled in the Blue Shield programs alone. No report was made, of course, on the Wisconsin Plan of the State Medical Society or the plans of private insurance companies or consumer sponsored plans.

Delaware leads all states with 48 per cent of its population enrolled in Blue Shield. Michigan is second with 22 per cent.

85 WISCONSIN HOSPITALS WIN APPROVAL OF THE AMERICAN COLLEGE OF SURGEONS

Chicago, Jan. 5.—Eighty-five Wisconsin hospitals were awarded full or provisional approval by the American College of Surgeons at the conclusion of its annual hospital standardization survey.

The survey list included 3,998 hospitals throughout the United States, of which 82% were approved. Every hospital is reconsidered for approval each year.

List Requirements

The listing indicates hospitals of 25 beds and over which have complied satisfactorily with the fundamental requirements that the College believes assure the best care of the sick and injured. These include modern physical plant, well defined organization, carefully selected governing board with complete authority, competent administrative officers, adequate and efficient personnel, organized medical staff of competent ethical physicians, adequate diagnostic and therapeutic facilities, accurate, complete medical records, regular staff conferences and a humanitarian spirit.

The Wisconsin hospitals approved by the College are:

St. Elizabeth, Appleton; St. Joseph's and Trinity, Ashland; Pure-air Sanatorium, Bayfield; St. Joseph's, Beaver Dam; Beloit Municipal; Burlington Memorial; St. Joseph's, Dodgeville; Luther hospital and Mt. Washington Sanatorium, Eau Claire;

Lakeland, Elkhorn; St. Agnes, Fond du Lac; Bellin Memorial and St. Mary's Green Bay; Middle River Sanatorium, Hawthorne; Mercy and Pinehurst Sanatorium, Janesville; Riverview Sanatorium, Kaukauna; Kenosha hospital, St. Catherine's and Willowbrook Sanatorium, Kenosha; Grandview, La Crosse, La Crosse Lutheran, and St. Francis, La Crosse;

Lake View Sanatorium, Madison General, Methodist, Morningside Sanatorium, St. Mary's, Wisconsin General and Wisconsin Orthopedic Hospital for Children, Madison;

Holy Family, Manitowoc; Marinette General; St. Joseph's, Marshfield; Holy Cross, Merrill;

Columbia, Evangelical Deaconess, Johnstown Emergency, Children's, Milwaukee Hospital, Misericordia, Mt. Sinai, Mulrdale Sanatorium, Sacred Heart Sanitarium, St. Anthony, St. Joseph's, St. Luke's, St. Mary's Hill Sanitarium, St. Mary's, St. Michael, Shorewood Hospital-Sanitarium, and South View, Milwaukee;

St. Clare, Monroe; Theda Clark Memorial, Neenah; Oak Forest, Sanatorium, Onalaska; Mercy, Oshkosh; Rocky Knoll Sanatorium, Plymouth; Divine Savior General, Portage; St. Alphonsus, Port Washington; St. Luke's, St. Mary's and Sunny Rest Sanatorium, Racine;

St. Mary's Rhinelander; Lakeside Methodist, Rice Lake; Sheboygan Memorial; St. Mary's, Sparta; Wisconsin State Sanatorium, Statesan; River Pines Sanatorium, and St. Michael's, Stevens Point; Door County Memorial, Sturgeon Bay; St. Mary's, Superior; Sacred Heart, Tomahawk; St. Mary's, Watertown;

Waukesha Memorial; Mount View Sanatorium, St. Mary's and Wausau Memorial, Wausau; Milwaukee County, Milwaukee County Hospital for Mental Diseases and Milwaukee Sanitarium, Wauwatosa; Hickory Grove Sanatorium, West De Pere; Maple Crest Sanatorium, Whitelaw; Sunny View Sanatorium and Winnebago State at Winnebago.

MADISON BECOMING RESEARCH CENTER

Madison, Jan. 27.—The City of Madison is rapidly becoming a great national center of research as the result of the establishment of new research laboratories and institutes.

Five Laboratories

Most such laboratories are located at the University of Wisconsin, as might be expected. Playing an active part in bringing these laboratories to Madison is the Madison and Wisconsin Foundation. Among the new facilities are the $500,000 University Alumni Research Foundation Laboratories, the Federal Barley Malt Research Laboratory, the McArdle Cancer Research Institute, the Dairy Industry Building and Laboratory and facilities for heart research.

Serves Entire State

The University of Wisconsin Foundation, which is undertaking to raise $5,000,000 with which to erect a $3,500,000 Wisconsin Continuation Center building on the campus, recently reported that the progress being made in research fields helps the University to serve the state and nation. "But most important of all, the University is serving you as an individual. Perhaps you know of someone who is alive today because of discoveries made by scientists at this great institution."

DR. R. E. FITZGERALD

Dr. Fitzgerald is Conference Secretary

Chicago, Feb. 6.—Dr. Robert E. Fitzgerald, Milwaukee, was named secretary of the National Conference on Medical Service for 1951. The Conference is an outgrowth of the North Central Conference of middle west state medical societies. It is devoted to discussions of problems concerning medical economic matters and the provision of medical care to the public.

Dr. Fitzgerald's election to the post of secretary automatically makes the Wisconsin State Medical Society host for the 1951 Conference in Chicago. This is the second time in 18 years that the honor has come to this state.

DRUGGISTS OPPOSE FEDERAL MEDICINE

Madison, Feb. 12.—The Wisconsin Pharmaceutical Association recently went on record as opposing "national compulsory health insurance or any system of medical care which threatens the private enterprise status of the health professions or makes it impossible or difficult for the patient to exercise a free choice of pharmacist, physician or dentist."

The association went on to express its eagerness to "assist in working out an acceptable program which will make more adequate medical care available to all our people."

To date, more than 125 organizations in Wisconsin have taken official action in opposition to government compulsory health insurance programs.

Disability Features of Social Welfare Proposals Seen as Step to Nationalization

AMA Warns H. R. 6000 Will Result in Federal Medical Care

Washington, D. C., Dec. 22—The Senate Finance Committee has been advised by the A. M. A. Board of Trustees that H. R. 6000, the Social Security Bill already passed by the House of Representatives, has serious medical implications which do not warrant its passage in its present wording.

The following is a statement by the Board of Trustees made on December 8, 1949:

"In the past, the American Medical Association has made it a practice to take a stand on legislation involving medical care and the health of the American people. While H. R. 6000 is primarily a social welfare proposal, it does contain one provision having serious medical implications, namely that section on compulsory contributory permanent and total disability insurance.

No Controls

"The major benefits included in the present social security system —old age and unemployment—are adaptable to mass or objective administration from an office remote from the individual. This is not true of total and permanent disability benefits. Age is a condition over which the individual is unable to exercise any control, and unemployment is an occurrence over which the individual may have little or no control. Qualification for the benefits is categorical and not difficult to determine. In contrast, total and permanent disability is often a condition over which the individual who is disabled and his physician may exercise control.

Wide Subject Matter

"This subjective control which may be exercised by the individual multiples the opportunity for malingering and actually takes the program out of the insurance category. We must always oppose any program which places a brake on the incentive of the sick and disabled to desire recovery.

"To initiate a federal disability program would represent another step toward wholesale nationalization of medical care and the socialization of the practice of medicine. The program as now proposed would not accomplish the entire nationalization of medical care, but the inevitable expansion and liberalization of the program which would surely follow makes probable its eventual accomplishment. The steps in liberalization are not hard to visualize—such as payment of benefits to dependents of disabled covered persons, removal of the time lag of six months and substitution of temoprary disability benefits, then eventually full cash sickness and disability provisions. We would then have nothing less than a total national compulsory sickness program.

"The American Medical Association recognized the need for assistance to the disabled-needy and feels that this aid should always be administered on a local level. Financial assistance to the locality should only be advanced from state or federal sources when a need can be clearly shown."

AMA Says Standardized Medicine Won't Work

Chicago, Dec. 31.—It was inevitable that sooner or later someone would have to admit that "free" medicine per se is impossible, declares the Journal of the American Medical Association.

The editorial points out that British Health Minister Aneurin Bevan has had to admit the necessity for economy measures and now all except old age pensioners must pay the first shilling (14 cents) on all prescriptions.

States the editorial, "Mr. Bevan is reported to believe that other economies can be achieved by standardizing drugs and other medical supplies. Such 'standardization' would mean, of course, further limitation for the patient and the physician; not only would the best possible medical service then be limited, as has been observed under the act during the first year of enforcement, but remedies would be limited.

"Apparently, the so-called social planners seem to regard physicians as automatons and patients as gadgets with standard equipment produced on a production line."

POSTGRADUATE EDUCATION

(Continued from page 1)

Paralysis, Mr. Palmer Daugs, Lake Mills; Wisconsin Chapter of the American Academy for General Practice, Dr. D. C. Ausman, Milwaukee; Wisconsin Anti-Tuberculosis Association, Dr. A. A. Pleyte,

Increases Malingering

Milwaukee; Wisconsin Division of the American Cancer Society, Dr. A. R. Curreri, Madison, and the State Medical Society, Dr. W. S. Bump, Rhinelander.

Dr. Bump said the proposed short courses for doctors are aimed at the general practitioner and will cover "not just one disease or one organ, but will present subjects to help him give better treatment to the whole human being."

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BULLETIN
OF THE
WISCONSIN STATE NURSES ASSOCIATION

VOL. XVIII JANUARY, 1950 No. 1

President's Message

You nurses who attended the annual meeting will remember that we received a letter from the Wisconsin Medical Society asking us to take a stand on the question of socialized medicine. We voted to give this question consideration in our own district meetings before giving any expression of opinion.

I am very glad we took the action that we did. Many organizations are inclined to express opinions without benefit of clear thinking. We, as individuals and as a group, are interested in providing adequate nursing service for all. We must apply this principle when we are deciding whether or not a movement meets our sanction. In considering socialized medicine or any other subject of a controversial nature, may we always obtain as much information as possible on both sides. Individual thinking may be biased if every angle of a subject is not presented.

As nurses interested in health and welfare, we owe ourselves and the community a careful study of problems affecting that health and welfare. In this instance it is important that we understand what has been achieved, good and bad, in the countries that have tried socialized medicine. Again we must be sure we are not reading reports printed by biased people. Let's weigh the subject, pro and con, before we decide as individuals where we stand—this necessarily precedes group expression. In the meantime let's continue to contribute our very best to providing an adequate nursing program.

Ruth L. Coe

Above is an exact reproduction of the president's page in the Jan. 1950 Bulletin of the Wisconsin State Nurses Association. In other parts of the county, 2 national, 10 state and 17 local nurses groups have taken a positive stand against socialized medicine.

Committee Urges Improvement of Institutional Medical Practices

Request Appointment of Physician Consultants

Madison, Feb. 14.—Suggestions for improving the standards of medical practice in county mental institutions have been submitted to the department of public welfare by the State Medical Society's committee on mental hygiene and institutional care.

In a letter to John Tramburg, department director, the committee urged immediate employment of a physician on the staff of the department to correlate the professional services of Mendota and Winnebago and assist with an evaluation of medical and nursing services carried on in the county hospitals.

Dr. H. H. Christofferson, Colby, chairman of the committee, wrote that "because both state hospitals have close contact with all county hospitals through the referral of patients, it seems that continuous and systematic medical supervision of county hospitals could best be achieved through consultant services by the medical staffs of Winnebago and Mendota."

Urge Trustee Conference

"The state could be divided so that each would cover the area from which most of their referrals come," Dr. Christofferson added. He pointed out the necessity of having both the staff physician and consultant services of the two hospitals, and added that the funds are available for the employment of the state department doctor.

The committee also recommended a state-wide conference for trustees of county hospitals and key administrative personnel.

BOARD OF HEALTH NAMES NEW EDITOR

Madison, Jan. 13.—The appointment of Mrs. Dorothy O. Lindquist, Madison, as editor in the division of health education was announced recently by Dr. Stephen E. Gavin, Fond du Lac, president of the state board of health. She succeeds Mr. John Culnan who resigned Sept. 1. She received a journalism degree from the University of Wisconsin in 1948.

Act on Water Pollution

The board also revealed that it had taken action in several areas of the state to remedy water pollution hazards. The cities of Spooner and New Richmond and several industrial concerns in those areas were directed to cooperate in the development of plans for adequate sewage and industrial waste treatment facilities.

The reduction in the incidence of venereal diseases in Wisconsin following the war prompted the board to close 12 of its 14 state-city cooperative venereal disease clinics effective June 30, 1950, Dr. Gavin announced.

State Relief Rolls Double in 1949

Madison, Feb. 7.—Public assistance payments for hospital and medical care increased about one-third while the state relief rolls more than doubled in December, 1949 as compared with the same period in 1948.

This was revealed by George M. Keith, director of the state division of public assistance, who blamed continued high prices, industrial lay-offs and reduced working hours for the 106% boost in relief cases over 1948.

The total number of persons receiving all forms of financial assistance from the state in December, 1949 was the highest since January, 1943, and the amount of money paid out was the most since May, 1941.

Exactly 51,550 aged persons received grants totalling $2,441,846 during December, an average of $47.37. General relief grants accounted for $603,121 of the $4,136,000 paid out in some 66,000 cases covering 119,000 persons.

DOCTORS PRAISED BY UMW WELFARE FUND DIRECTOR

PLAN OFFERS FREE CHOICE OF DOCTOR AND HOSPITAL, NO FEE SCHEDULE USED

Chicago, Feb. 6.—Doctors working with the medical, health and hospital program of the United Mine Workers (UMW) Welfare and Retirement Fund have "voluntarily rendered services at as reasonable costs and high quality as could be obtained under *any* kind of plan," declared Dr. Warren F. Draper, UMW medical director.

Speaking at the National Conference on Medical Service in Chicago, Dr. Draper said the UMW has received "the finest cooperation from all the doctors in the coal mining areas."

Three Steps in Operation

The program was established in October 1948 upon the order of John L. Lewis, UMW president, according to Dr. Draper. A physician trained in administrative work was placed in charge of each of 10 area medical offices. These area medical administrators make all arrangements with doctors, hospitals, pharmacists and others.

The first step was provision of hospital and medical care in the hospital for UMW members receiving grants in the form of pensions or disability benefits. Their dependents were included.

Second was the provision of home and office care, including drugs on a physician's prescription, for the same group of people.

6,500 Doctors Take Part

Third was the extension of hospital care and medical care in the hospital to all working miners and their dependents. Home and office visits are not available under the plan to this group.

A fourth step, not yet under way, was the development of a public health and preventive medicine plan to improve living conditions. The other three measures were in operation until the temporary suspension of all benefit payments in September 1949 during negotiations between miners and the coal operators.

The program operates as follows, according to Dr. Draper:

Area medical administrators arrange with individual physicians, hospitals and drug stores to provide services to beneficiaries of the fund upon presentation of accepted forms of identification. Physicians must be in good professional standing and acceptable to the Union members. They must agree to render the services according to operating procedures of the Fund and at a "reasonable charge."

The UMW fund does not operate through a fee schedule. Payment must be satisfactory to the physician providing his charges are not excessive as compared with similar services by others of equal standing.

Patients have free choice among participating physicians, hospitals and drug stores.

To date, some 6,500 physicians and 600 hospitals are participating. In the first eight months of operation, 39,000 persons were hospitalized and 375,000 days of hospital care provided. A total of 180,000 home and office visits were made.

Dr. Draper praised the "excellent" cooperation of the profession, and added that the relatively few problems can probably be ironed out with experience.

Pay Tribute to State Hospitals and Blue Cross

Milwaukee, Feb. 10.—Governor Oscar Rennebohm paid tribute to the accomplishments of Wisconsin hospitals and Blue Cross in helping to ease the burden of payment for hospital services by declaring the week of Feb. 12 to 19 Blue Cross Hospital Service Week.

SMS Surveys Hospitals on Care of Mental Cases

Call Attention to Lack of Facilities for Patients

Madison, Feb. 14.—A complete survey of present practices and facilities in general hospitals regarding the care of mentally disturbed patients has been started by the State Medical Society's committee on mental hygiene and institutional care.

Too many hospitals at the local level lack adequate facilities to care for patients suffering from mental disturbances who are in need of hospitalization for surgery or medical care preceding transportation to either Winnebago or Mendota for psychiatric treatment.

It has been reported that some mental patients must go without medical or surgical treatment because the local hospital hasn't the proper housing or nursing service or prefers not to disrupt the atmosphere of quiet maintained for other patients.

The committee believes that the general hospital at the local level has a responsibility for giving emergency care on the local level in those cases where transportation to the state hospital at either Madison or Winnebago would be dangerous to the health and welfare of the patient.

A communication from the committee to all Wisconsin general hospitals urges development of at least limited facilities, isolated from other patients and with proper safeguards to avoid self-annihilation of the patient.

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Badger Regional Blood Center in Madison to Serve 16 Counties

Madison, Feb. 15.—A prescription for saving lives is being written in southern Wisconsin by the American Red Cross in cooperation with the medical profession, the hospitals and public health workers.

When it is "filled" by the completion of a blood donor center in Madison and establishment of a mobile donor unit the magic of blood will be available for all in that area.

A blood bank center, to be known as the "Badger Regional Blood Center" is being set up in Madison in the headquarters of the Wisconsin Division of the Red Cross. It grew out of a request from the officers of the Dane County Medical Society and representatives of Dane county hospitals.

Need 20,000 Pints

A survey of blood needs in southern Wisconsin had earlier shown that the hospitals and physicians need about 20,000 pints of blood annually. The new center will provide at least this amount for approximately 16 counties.

Local physicians in each community control the program in their area at all times. Before the Red Cross can begin a "branch" of the Madison center in any county, the local doctors, hospitals and health officials must decide whether they need it. If they think so, they make a request to the Red Cross.

The doctors and hospitals of La Crosse, in cooperation with health officials and the public, are now organizing a "Hospital Blood Bank" as a non-profit civic venture to service patients requiring blood transfusions.

Dr. D. M. Buchman is the county medical society representative on the group responsible for its establishment.

To date, requests have come from Columbia, Walworth, Jefferson, Grant, Juneau, Lafayette, Richland and Vernon counties. Milwaukee, Kenosha, Racine, and Rock counties will probably not enter the scheme because they already operate successful blood programs.

Direction of this huge project is in the hands of Dr. Merle Owen Hamel, Portage, who was selected by the Dane County Medical Society. She received her medical degree from the University of Wisconsin in 1936.

DR. M. O. HAMEL

When the program is started, all technical, medical and distribution problems are under the direction of a medical advisory committee in each county, named by the local medical society. The Red Cross has nothing to say about who shall receive blood. There is no interference with the private doctor-patient relationship.

Doctors Control Plan

Each county medical society will be asked to send one member of its advisory committee to the Regional Council of the Red Cross blood program. This is the highest policy body on the technical and scientific level. Only physicians will be members of this Council.

All responsibility for procurement of the blood and its delivery to the place where it is needed belongs to the Red Cross. A regional council of laymen without medical representation operates at the state level to handle this phase. Local Red Cross chapters will be responsible for obtaining donors to fill blood quotas. Mrs. Laura Davies, director of the Wisconsin Chapter of the Red Cross, estimates that a half-year's supply of donors must give pledges for blood before the plan can begin.

The blood, or its fractions, will be provided without cost to all who need it and in such quantities as they need. The hospital or doctor may charge a fee for administering the blood, but the Red Cross has asked that such costs be kept at a minimum.

When Red Cross blood is "spent" from the bank, the doctors and hospitals will generally try to obtain replacement deposits from relatives or friends of the patient. However, the major portion of Red Cross blood will be obtained from public-spirited citizens who will donate their blood at the Madison center or at mobile units which will visit each county every month.

California Develops "Catastrophic" Care Plan

Pays Up to $5,000 Benefits for 20 Chronic Illnesses

San Francisco, Feb. 12.—Catastrophic health protection against medical and surgical costs of polio, cancer, tuberculosis and 20 other serious diseases and ailments has been announced by California Physicians' Service, the Blue Shield plan sponsored by the California Medical Association.

Full Payment Feature

It is the first medical society sponsored plan to provide such a comprehensive catastrophic coverage for chronic and long-term illness.

California Physicians' Service will pay for medical and surgical services for a period of two years from the date of the first illness or until $5,000 in benefits has been paid, whichever event occurs first.

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At the present time, the plan is offered only to CPS members who are covered in groups. It is not possible to subscribe for catastrophic coverage alone, but it must be in addition to an existing group medical-surgical contract.

The monthly rates for adding this coverage to the other contracts are:

Male	**$ .70**
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Protection is provided for cancer, tuberculosis, diabetes, polio, osteomyelitis, rheumatic fever, brain tumors, and other diseases.

National Conference Points Way to Improvement of Rural Health

Kansas City, Mo., Feb. 5.—Rural health problems are steadily being solved through cooperative community efforts was the consensus of the recent AMA national conference on rural health to which the State Medical Society of Wisconsin sent several representatives.

And it is being done in the American way, through unity, not uniformity, reports Dr. M. W. Stuessy, Brodhead, chairman of the Society's committee on rural health. He participated in a preconference meeting of chairmen of state rural health committees where the major topics were discussed.

How to Get a Doctor

The conference brought together more than 500 medical and lay leaders concerned with providing medical care to small communities. Among the recommendations for further progress were:

1. Community health councils can play a leading role in securing community participation to attract doctors by providing hospital and clinical facilities and to make community life attractive to them and their families.

2. An intensified education program is needed to acquaint people with facilities available to them.

Praise Teaching Plan

3. Tax funds should be used to provide medical care only when it is impossible for an individual to secure such care without such help.

The conference pointed to the need for a more realistic measurement of health and hospital needs. It was reported that many of the hospitals built with federal aid under the Hill–Burton act were being used only to half capacity. Criticism of the Hill–Burton act was voiced by several who indicated that construction costs under the act were high because of unnecessary building requirements in the law.

Dr. Robert Parkin, coordinator of postgraduate medical education at the University of Wisconsin, participated in the section on medical education in relation to rural practice.

DR. ROBERT PARKIN

Strong endorsement was given the extension of postgraduate teaching into regions beyond the usual service areas of medical schools. This program is well under way in Wisconsin through plans of the medical society's council on scientific work to set up "extension teaching centers" in the state in 1951.

FIVE OUTSTANDING 4–H CLUB LEADERS in Waukesha county were on hand to receive the State Medical Society's 1949 certificate for notable achievement in health. Left to right are Mrs. C. E. Butler, Lucky Seven 4–H club, Sussex; Dr. F. L. Grover, Hartland, secretary of the Waukesha county medical society who made the presentation; Mrs. Emery Smale, Ward 4–H club, Eagle; Mrs. William Holmes, Fussville 4–H club, Menomonee Falls; Mrs. Ernest Kraft, Summit Valley club, Oconomowoc, and Mrs. Laurel Smart, Eagle 4–H club, Eagle.

DR. RUSSELL IS MAN OF THE YEAR

Fort Atkinson, Wis., Feb. 20.—Dr. James C. H. Russell, who came to Fort Atkinson only two years ago, and who has found his way into the esteem of hundreds of homes in that community, was named the city's "outstanding young man" and received the Distinguished Service Award of the National Junior Chamber of Commerce.

Dr. Russell attended Racine–Washington Park high school and is a graduate of the University of Wisconsin medical school.

The award winner has contributed greatly to community affairs, attends all high school athletic games where he gives his professional services for injury on the field of play without charge. He has also given free examination to members of all youth organizations in the city.

He is a member of the Fort Atkinson Memorial hospital staff. As a father of three sons he has been extremely active in school affairs and claims a 100% attendance record at P. T. A. meetings. He is a Rotarian, a respected leader in youth groups, active in promoting the Wisconsin Foundation, Young Farmers of America and the Chamber of Commerce.

AN ESTIMATED 2,500 PERSONS viewed the four large exhibits sponsored by the State Medical Society's Rural Health Committee at the annual Farm and Home Week in Madison, Jan. 30–Feb. 2. The displays included medical quackery devices, tularemia, brucellosis, and examples of how the State Medical Society and the State Board of Health work for the health protection of the people.

AMA Heads Urge MDs to Put House in Order

Outline 1950 Education Campaign Objectives

Chicago, Feb. 13.—A spirit of enthusiasm and determination was clearly evident among the 150 physicians and medical society lay executives who attended the second national conference on the American Medical Association's national education campaign here on Feb. 12.

The note of optimism engendered by the fact that there is little or no chance for passage of the administration compulsory health insurance bill during 1950 was well tempered by the realization that the "showdown" is still ahead and that "medicine still has much to do to put its own house in order."

Dr. Ernest E. Irons, president of the AMA, repeatedly emphasized that putting "his own house in order" can be one of the doctor's greatest contributions to the Whitaker and Baxter educational campaign.

"We must provide satisfactory means of answering night and emergency calls, do our best to eliminate errors in the care of patients and to prevent overcharging," Dr. Irons stated. "All of these must be accomplished at the county level."

Miss Leone Baxter, general manager of the national education campaign, repeated Dr. Irons' admonition with the added statement that "medical men in their own communities must show that they can do a better job than the federal government." Concerning the campaign, she said that more than 3,000 organizations are now formally recorded as opposed to socialized medicine.

Fear "Fringe" Bills

Clem Whitaker, director of the campaign, pointed out that medicine is "no longer faced with a single bill for compulsory health insurance, but with a series of 'fringe' measures disarming in language but dangerous in implication."

He referred to bills on medical education, child health and expanded social security. "No one of these bills alone will accomplish socialized medicine," he said, "but each completes a part of the whole compulsory government program."

Medical Dean Talks at Farm & Home Week

Denies Doctors Restrict Medical School Output

Madison, Jan. 31.—The only way to solve the doctor shortage and distribution problem "is to give medical schools more money so they can give adequate training to more students without compromising quality," declared Dr. Franklin D. Murphy, dean of the University of Kansas Medical School, at the annual Wisconsin Farm and Home Week, Jan. 30–Feb. 2.

Need Joint Action

Dr. Murphy was brought to the Farm and Home Week program through the courtesy of the State Medical Society.

Regarding the shortage of physicians, Dr. Murphy pointed out that if the public will spend the money, the medical school would like to expand. The whole problem depends on "enlightened, joint action by producers of medical care—doctors and hospitals alike—and the consumers of medical care."

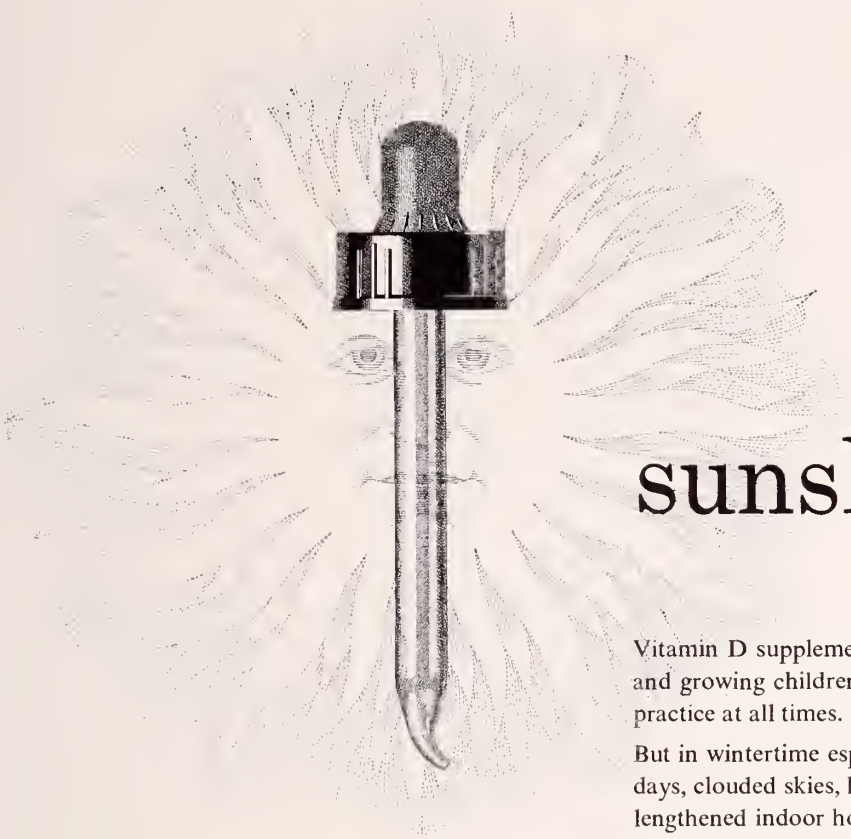
He said the doctor going to rural areas needs adequate facilities in which to practice medicine, opportunity to attend refresher courses to guarantee that he will not be "professionally isolated," and an understanding on the part of the community that young men are not going to be attracted to dying communities.

No Petrillo Tactics

Dr. Murphy also took exception to the recent action of the Association of Academic Deans in accusing the medical profession of "Fishbein and Petrillo" tactics in reducing the number of medical schools and making a concerted effort to limit the number of doctors.

A return to the "diploma mill" schools of the 1900's is dangerous and impossible, he said. Such schools were closed by the dozen and since then, he said, there has been an improvement in the number and quality of amalgamated medical schools.

"The people have a greater stake in medical education than do the doctors themselves," he declared. "Poor training will hurt the people, not the doctors."



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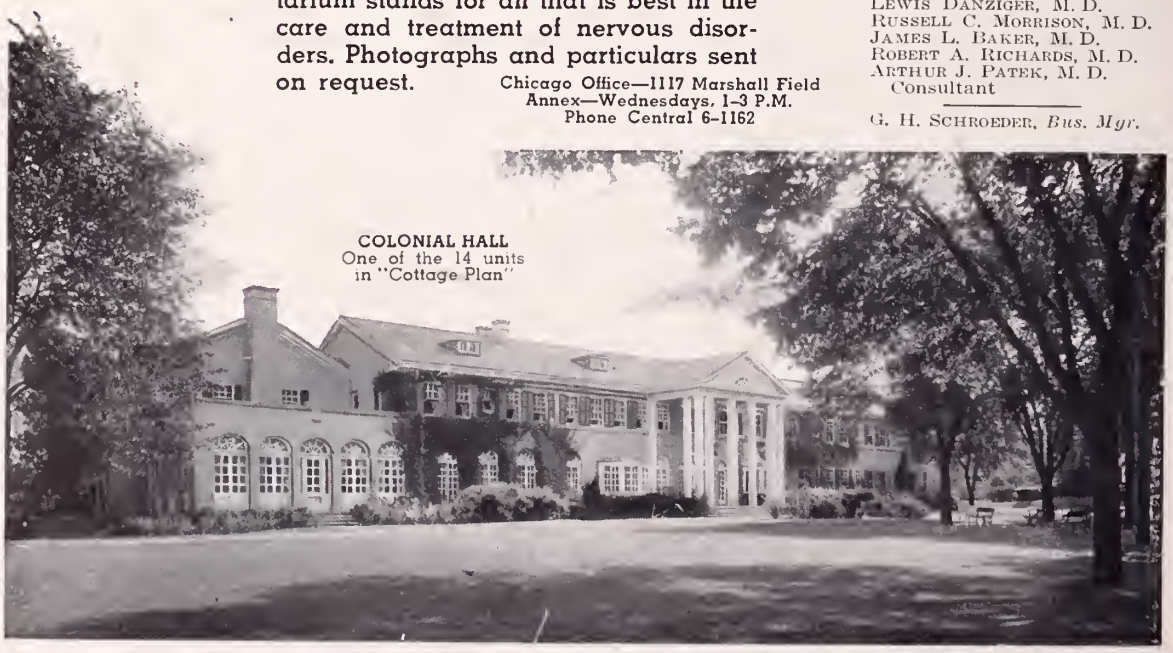

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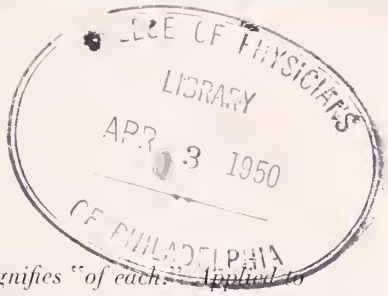

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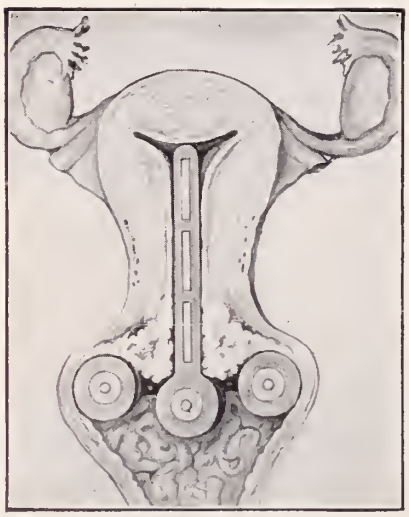

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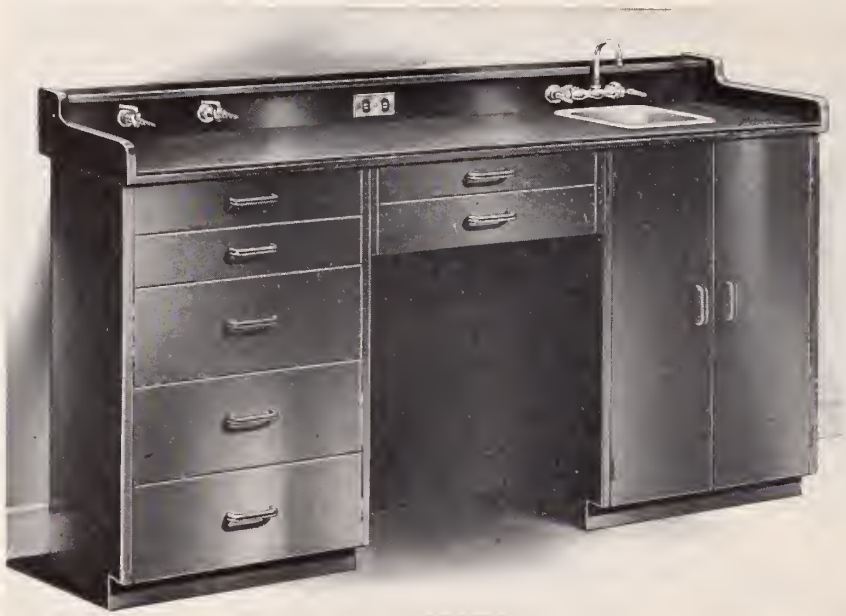

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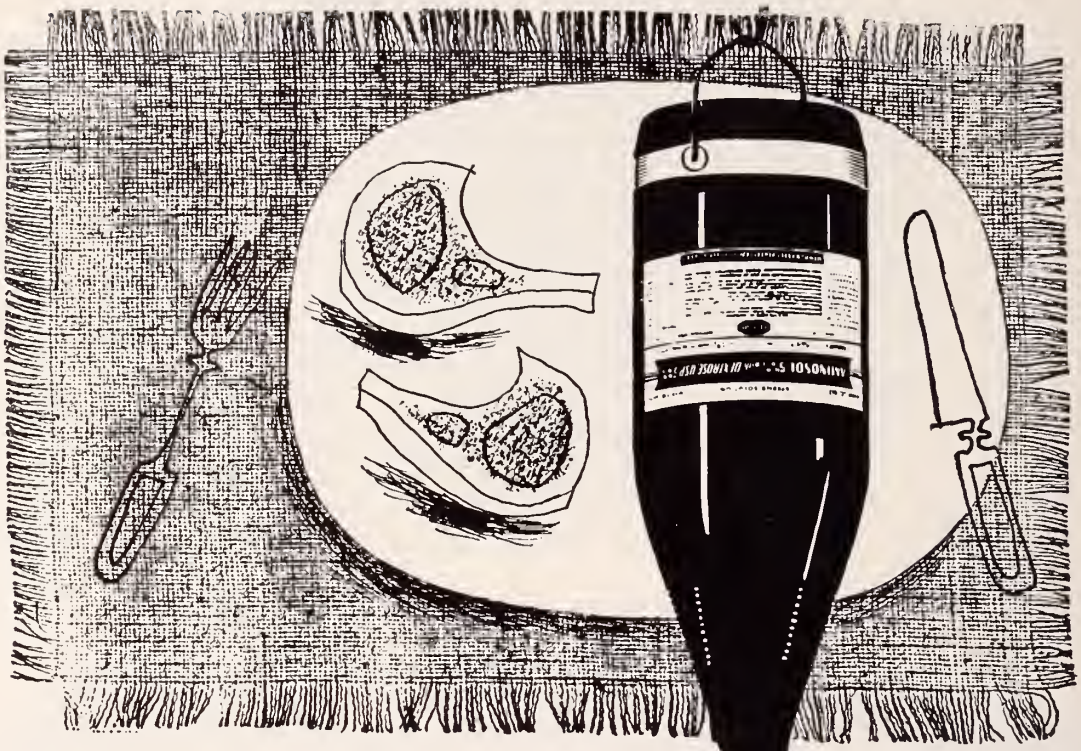

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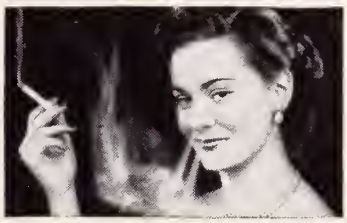

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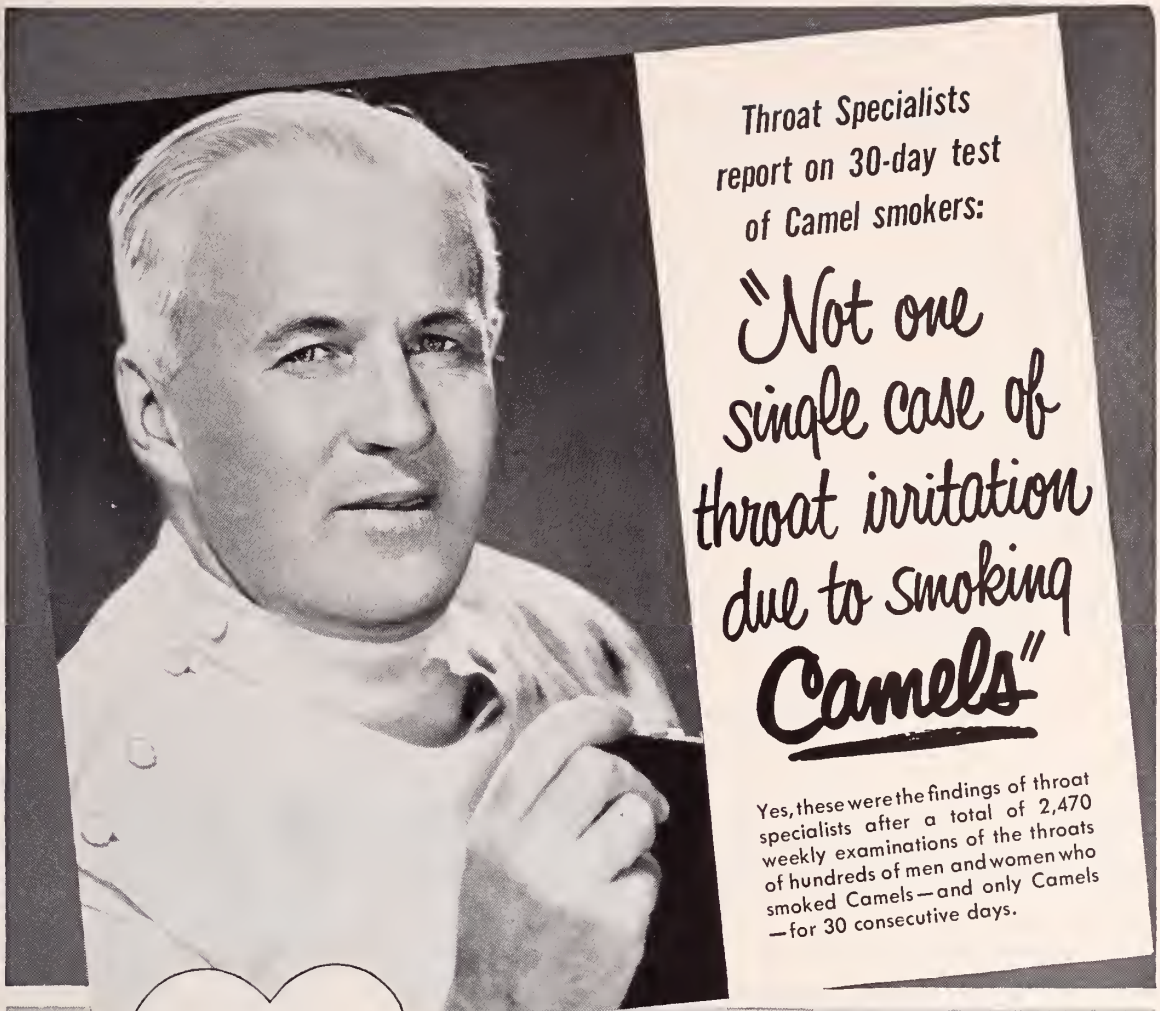

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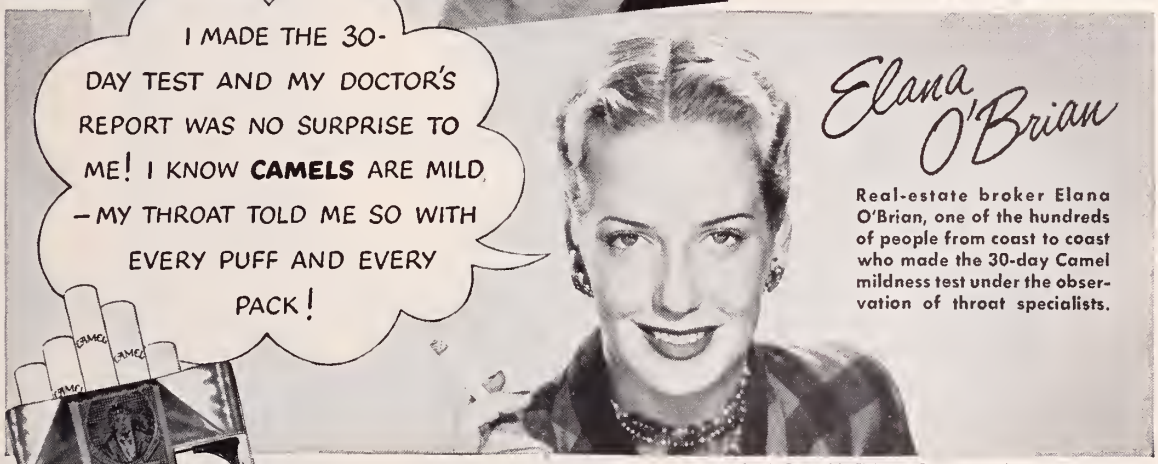

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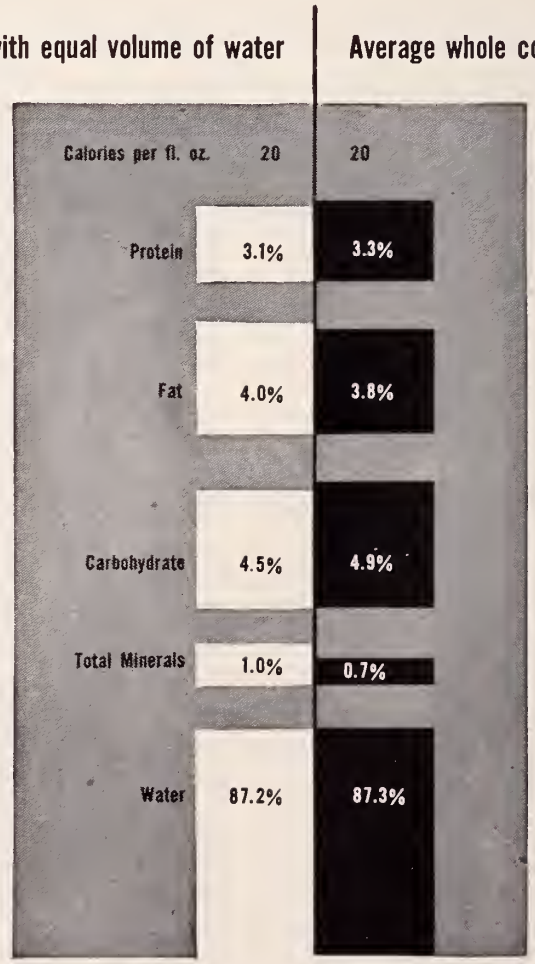

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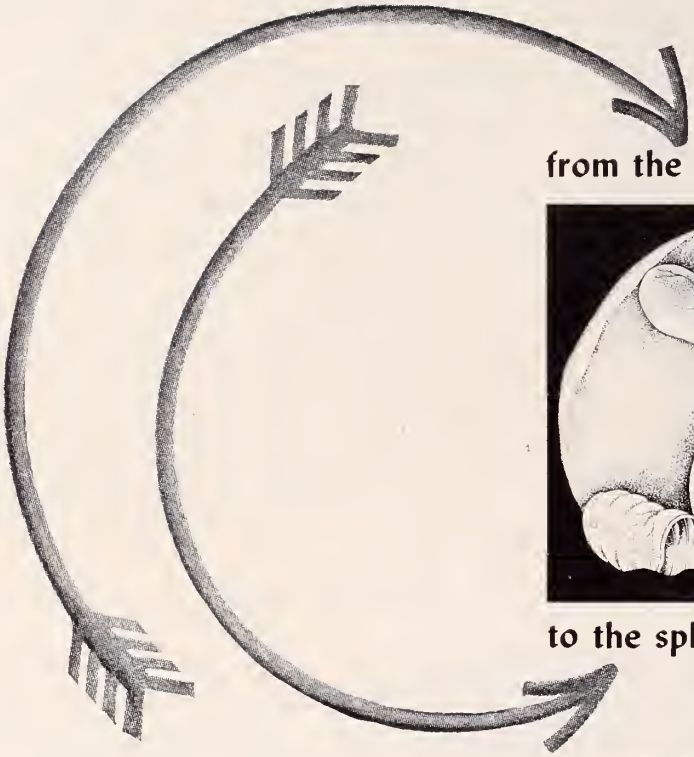

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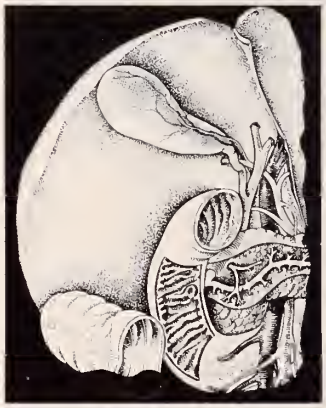

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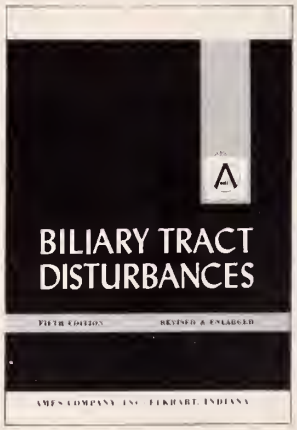

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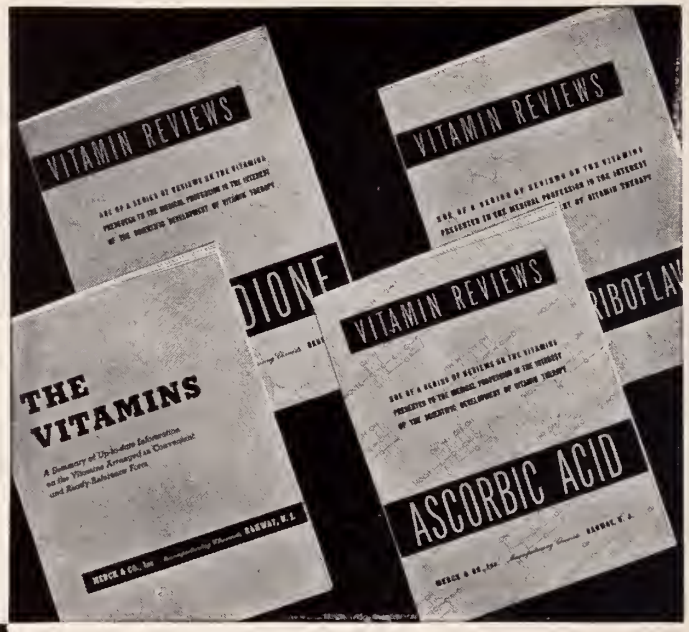

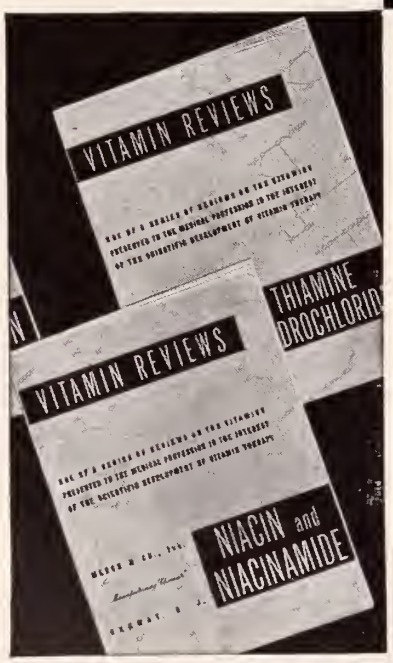

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- **Clinical use in specific conditions.**

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« « « EDITORIALS » » »

Water Fluoridation for the Control of Tooth Decay

Sixteen cities in this state are adding fluoride to their public water supply to raise the concentration of the fluoride ion to the optimum level of 1.0 to 1.2 parts per million parts of water.

Fluorine has been known to be a constituent of teeth for a long time, but its function is not known with certainty at the present time. There are data available which definitely show that pulverized tooth enamel treated with a soluble fluoride acquires resistance to solubility by a solution of lactic acid. In 1931, Churchill found a high fluoride content of the water supply at Bauxite, Arkansas, associated with a severe mottling of the teeth, now designated "dental fluorosis." But long before this finding, McKay at Colorado Springs, Colorado, had noticed a mottling of the teeth of his patients in that city, but not in those patients coming from the area outside the city and not using the city water. Following the finding that fluorides caused "dental fluorosis," surveys of various cities were begun to determine the extent of the defect and its quantitative relationship to the fluoride content of the municipal waters used. In general, it was found that some slight dental fluorosis accompanied the use, from birth to adult life, of waters containing 1.5 parts per million and that as the fluoride content of a municipal water was found higher than this amount the mottled enamel defect became more pronounced. When the fluoride content of the water consumed from birth to adult life was found to be above 4 parts per million, all of the teeth showed the mottling and many of the teeth developed a brownish stain and some pitting. All in all, it appeared that excessive fluorides in waters produced a defect in tooth enamel. As these surveys were progressing it was generally noted that dental caries were greatly decreased amongst those persons who had the enamel defect, and that this decrease in tooth decay was also much less in those cities in which the fluoride content was above 1.0 parts per million, but not high enough in fluorides to cause the disfiguring mottled enamel. Some twenty to thirty surveys were then made comparing the dental decay rate of cities in the fluoride range, 1.0 to 2.0 parts per million fluoride, with those cities using waters with practically no fluoride content, 0.0 to 0.2 parts per million. Every one of these surveys, without any exception, showed that children reared on these fluoride-

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free waters had nearly three times as much tooth decay, D. M. F. (decayed, missing, or filled) as those children reared on waters containing 1.0 to 2.0 parts per million fluoride.

Such a constant finding, and accompanied by no noticeable mottled enamel when 1.2 parts per million of fluoride was present in these waters, stimulated public health officials, dentists, physicians, and other persons interested in the control of rampant dental decay to advocate and initiate the fluoridation of public water supplies low in fluorides. This is done by the addition of sodium fluoride in sufficient amount so that the drinking water will contain 1.0 to 1.2 parts per million of fluoride ion. In the United States, outside of Wisconsin, there are about fifteen cities adding fluorides. Grand Rapids, Michigan; Newburgh, New York; Marshall, Texas, Charlotte, North Carolina; and Evanston, Illinois, are some of these. In Wisconsin the following cities are supplementing their municipal drinking water with fluorides: Ashland, Beloit, Baraboo, Fort Atkinson, Janesville, Antigo, Elkhorn, Edgar, Hartford, Madison, Mukwonago, Oshkosh, Richland Center, Sheboygan, Stoughton, and Soldiers Grove. In addition to this list, there are about forty other cities which have approved the supplementation of their water with fluoride and are awaiting the equipment.

The State Board of Health has given its approval to this fluoridation program, but require that each city obtain approval of plans and equipment before fluoridation is started. The fluoride can be applied easily to practically any water; and equipment is readily available to add it accurately. Tests are available to the plant operator for the daily determination of the amount present in the water.

Sheboygan started to add fluoride to their water about four years ago, and recent surveys have shown substantial reduction in tooth decay already; however, the maximum benefit will not be shown until after about ten years, since the fluoride must be built into the tooth structure during the formative period of the teeth.

The cost of the fluoridation of a municipal water amounts to between 10 and 20 cents per person per year.

From surveys already made of cities having the proper amount of fluoride present naturally and from preliminary reports from Sheboygan, Wisconsin; Marshall, Texas; Brantford, Ontario; and Newburgh, New York; it appears that mass control of dental caries is within the reach of all persons living in an area where municipal waters are used. Fluoridation is not a "cure all," but when used in conjunction with adequate diet and reasonable dental care, can be expected to reduce the decay rate about 65 per cent and provide better teeth for adult life.

A Thank-You to Doctor Karl Doege

Ten years ago, almost to the month, the Council selected a new editor for *The Wisconsin Medical Journal*. During these ten years he diligently applied himself to the job of reading and selecting papers for the scientific section of this magazine. It was not casual reading, as everyone knows who has done a similar job. It was close reading, searching for clarity of expression and for the selection of factual material suited for a group of physicians whose professional interest varies widely.

The man they selected for this important job was in the busiest period of his professional career. His time was occupied during the day in the hospital, in the office and often in making calls to see patients whose complaints were a challenge to one with a wide knowledge of medical literature and a sympathetic understanding of their complaints. Still he found time somehow to peruse carefully and with understanding the hundreds of manuscripts which came to him each year, some of them papers read to the various sections of the State Medical Society during its annual sessions and others spontaneous contributions by those who wished to present to the profession observations which they had found helpful in their practice.

During this busy ten years his service to Wisconsin medicine was not confined to work with the Journal. He was also carrying a heavy load of committee work, and often at annual meetings of the Society his wise leadership was needed and called upon to steer an important conference committee into quiet waters and to conclusions arrived at by calm and deliberate debate. And, it is not surprising that the last two years were also devoted to the offices of President-elect and then President of the Society.

We all understand that time had to be taken away from many other things which he would have chosen to do if loyalty to medicine and his profession had not had a stronger call. In his family, service to the advancement of medical science and practice has become a tradition. His father before him made notable contributions to medical practice and was honored by his conferees and contemporaries with the Presidency of the State Medical Society and his brother had preceded him as editor for a brief period.

The Council at the February meeting accepted the resignation of Dr. Karl Doege as Editor of the Journal and selected one of his associates, Dr. R. S. Baldwin, as his successor.

It is not only to compliment Doctor Doege but to thank him for a brilliant job as Editor and to express our appreciation for his loyal service and leadership that this note is written.

Nor does it mean that he is being released from further duties, for he now has been called upon to assume leadership in the field of voluntary sickness insurance, the success of which will mean so much to physicians and to the welfare of the public.

Current Problems in the Diagnosis and Treatment of Brucellosis*

By C. WESLEY EISELE, M. D.
Chicago

C. W. EISELE

An associate professor of medicine at the University of Chicago School of Medicine, Doctor Eisele graduated from Northwestern University Medical School in 1931. He served his internship at Presbyterian Hospital, Chicago, and a residency at Charity Hospital, New Orleans. Doctor Eisele has been associated with the University of Chicago Clinics since 1934.

HUMAN brucellosis is an important infectious disease throughout this country, but in any given area the incidence is closely dependent upon the size and importance of the dairy and food-animal industries. Virtually in every case, the disease in human beings originates from an infected animal. It has been said that "human beings become involved with brucellosis as a result of being unfortunate trespassers on the road that the organisms travel from animal to animal."[1] We can hope that eventually human brucellosis will become a disease of the past through the eradication of the disease in domestic animals.

Brucellosis in animals is important to human welfare in quite another way. The disease is a major cause of loss in the production of both milk and meat. Huddleson has made estimates of the magnitude of this problem in Michigan.[1] Blood test sampling indicated that brucellosis was present in about 10 per cent, or 100,000, of the million head of dairy cattle in that state. It is known that an infected cow produces on the average about 25 per cent less milk than a healthy animal. This means an average of about 2,000 pounds less milk per infected cow per year. In this one state then, it is estimated that the loss of milk production due to brucellosis in cattle would have been enough to supply the annual milk needs of 557,000 people, or about enough to have provided milk for the entire population of Milwaukee. In addition, it is estimated that in this one state more than 16,000 calves are lost annually due to brucellosis in cows. This would have provided 1,250,000 pounds of veal, or, if the calves had been allowed to grow up, 6,500,000 pounds of beef. The problem in Wisconsin probably is even greater than that in Michigan, due to the size and importance of Wisconsin's dairy industry.

Brucellosis in swine and its effect on pork production has not entered these estimations, but this is a problem of no little importance. The role of swine brucellosis in disrupting the disease control program for cattle is also deserving of serious attention.

It has been frequently said that human brucellosis is an important disease, but how important it is no one really knows. Estimations on the number of current cases in the United States have ranged from 40,000 to 4,000,000.[2] There is little reliable data to support these estimates, so that they are little more than guesses. This situation exists largely because of the difficulty in diagnosing the disease, and particularly because of the state of confusion surrounding the so-called chronic type of brucellosis. There is no question that a long-standing chronic form of the disease does exist, and it may be characterized by a multitude of symptoms which are indefinite and variable. Often the symptoms closely simulate those of the psychoneuroses. Undoubtedly many patients are misdiagnosed as neurotics. But the opposite error is probably made even more frequently. Many vague complainers are labeled as victims of brucellosis, with little or no objective evidence to support this diagnosis. No doctor in general practice is ever without a full quota of vague complainers that sorely tax his diagnostic and therapeutic acumen. The label of brucellosis may be readily attached to these trying patients if the physician is more enthusiastic than he is critical. But, as Alvarez has so aptly said, "It is usually a kindness not to give the psychopathic, constitutionally inadequate woman, who has had one illness after another for 30 years, the idea that all her troubles are due to brucellosis, that all the many good physicians who saw her throughout the years were incompetent, and that she could get well if only she could get enough streptomycin."[3] Today, it would be enough aureomycin or chloromycetin. I do not know what the current fad will demand next year.

The Diagnosis of Brucellosis

The great variability in the course and symptomatology of brucellosis and the dearth of distinguishing clinical features make one resort to laboratory tests for the diagnosis of this disease. Discussion of the laboratory examinations commonly used will be restricted to the interpretation and particularly to the limitations of the tests rather than to the technical procedures.

*Read before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

Recovery of the Causative Organism.—The only positive proof in the diagnosis of brucellosis is the recovery of the causative organism from the patient. Brucella have long been considered to be fastidious organisms that grow slowly and poorly and are difficult to isolate. Although this concept is generally true, advances in technic and improvements in culture media have greatly enhanced our chances of recovering brucella. All too often the physician has assumed the attitude that the difficulties were so great and the chances of success were so slim, that the effort and expense involved in trying to culture brucella were hardly worth while. Today, this attitude is not warranted. In addition to proper laboratory technic there are two secrets of success, both of which rest entirely with the clinician. The first is early attempt. The earlier in the course of the disease that cultures are taken, the greater are the chances of obtaining the organism. The second is persistence. Cultures should be made repeatedly, not just once. Although occasionally a patient may be seen with constant septicemia, this is the exception. Usually the organism is present in the peripheral blood only intermittently. Therefore, a daily blood culture for seven to ten consecutive days should represent the minimal diagnostic effort in any patient seriously suspected of having the disease.

Septicemia may be absent in many patients, particularly when the disease is chronic. Additional cultural methods may therefore be necessary. The culture of arterial blood after the injection of epinephrine to cause splenic contraction and presumably release splenic blood into the peripheral circulation, the culture of aspirated sternal marrow, the culture of hyperplastic peripheral lymph nodes, and the culture of any available surgical specimens are all worthy of trial. By each of these methods, we have been able to obtain the organism at times when the venous blood was repeatedly sterile.

By persistently using these methods, our group has obtained positive cultures from every patient that has been studied during the past five years in whom the disease was seriously suspected and from whom cultures were made during the first six months of illness. Positive cultures have also been obtained on occasion from patients with chronic infection of long duration, in some instances for as long as ten and twelve years.

These results were obtained with the facilities of a specialized research laboratory, but general practitioners with a special interest in the disease have also been able to obtain positive cultures in a high percentage of their cases by using facilities of state laboratories. For example, Dr. George Finch[4] of Des Moines, Iowa, has made the diagnosis of brucellosis in 201 patients during the past thirteen years. Cultural proof of the disease was obtained in 169 cases, or nearly 85 per cent of all those he diagnosed. Bottles of media furnished by the State Hygienic Laboratory were inoculated at the bedside, incubated for a few days in the hospital laboratory, and then mailed to the state laboratory 100 miles distant for further incubation and identification.

The Agglutination Test.—When cultural efforts fail, the agglutination test is the next most reliable examination, and undoubtedly it is the most widely used test of all. It is most unfortunate that there has been no standardization of this test for human brucellosis. Different laboratories perform this test with many deviations in technic and with antigens of widely varying sensitivities. The results thereby obtained by different laboratories on the same serum may be extremely variable. Samples of serum from 21 individuals, mostly from recovered, proved cases of brucellosis, were sent to five different laboratories in a routine fashion, and also were tested in our laboratory with a large variety of commercial antigens. The results reported on any one serum may vary in different laboratories from completely negative to positive in titers as high as 1/320 or 1/640 and in one instance as high as 1/1280.[5]

In addition to these technical difficulties, certain biologic variations may render interpretation of the agglutination test difficult. Occasionally in a patient with culturally proved brucellosis, agglutinins fail to develop in a significant titer. This occurrence is probably rare. We have not seen such a case in our own experience, nor has Doctor Finch[4] in Iowa. Nevertheless, some authors make much of this unusual occurrence, and the concept has been distorted to the point where negative agglutination tests are considered the rule rather than the exception in so-called chronic brucellosis.

On the other extreme, an occasional healthy individual may show a highly positive agglutination test for many years without evidence of past or present disease. Dooley,[6] among others, has reported several such instances. We have observed 1 man whose test has been positive in a titer of 1/5,000 repeatedly over a five year period. He appears to be in excellent health and he brags that he has never had a sick day in his life.

The question is frequently asked, what is a significant agglutination titer? In view of the foregoing discussion, it becomes clear that one cannot state arbitrarily that any one titer is diagnostic or significant. In general, the higher the titer, the more likely that it is associated with active infection. Probably titers of less than 1/160 are seldom significant, and we like to see an even higher titer before the test is given much weight. Strong evidence for active infection is provided where the test is negative early in the course of a febrile illness but subsequently becomes positive in progressively higher dilutions.

In interpreting the agglutination test, one must be alert not to be misled by an anamnestic response. Cross agglutinins engendered by other organisms may also be misleading. Tularemia, asiatic cholera, and what is more important in this country, vaccination against cholera[7] all may produce positive brucella agglutination tests. Brucella vaccine therapy, of course, may produce a marked agglutinin

response and may disrupt the interpretation of the test for months or years. Vaccine therapy should not be used in any case with a questionable diagnosis, if at all.

The Opsonocytophagic Test.—The opsonocytophagic test is not a practical method for general use for numerous reasons. It is subject to many sources of error, and requires a technic which is much more meticulous than that for the agglutination test. It requires the use of live virulent cultures of a smooth colony organism which is not without some hazard for the laboratory worker. Slight dissociation of the test strain renders the results worthless and misleading. The test must be performed within a few hours upon freshly drawn blood. Known positive and negative controls must be used on each occasion that the test is done. The test adds relatively little diagnostic information in most instances even when performed reliably. It is used in our laboratory as an additional research tool, but we do not recommend it for general or for occasional use.

The Brucella Skin Test.—The skin test is widely used, but probably is the most abused of all tests employed in brucellosis. A positive reaction indicates merely an allergy or a sensitivity to brucella protein. This may mean infection, either past or present, or it may mean an exposure to the organism without ensuing clinical disease. The test should be interpreted in the same fashion as the tuberculin test. Brucellergen, a purified brucella protein derivative developed by Huddleson, is the best standardized and generally the most satisfactory of all the many vaccines and bacterial products which have been proposed. We consider the skin test to be of little or no value in establishing a positive diagnosis, but a negative skin reaction is useful in conjunction with a negative agglutination test and, where feasible, a negative opsonocytophagic test in helping to render the diagnosis of brucellosis unlikely.

The Treatment of Brucellosis

The advent of each new chemotherapeutic or antibiotic agent brings an array of early enthusiastic reports on its efficacy in a great variety of infectious diseases. More extensive experience and critical observations on controlled material all too often show the new treatment to be of little or no value for the disease in question.

This course of events has occurred repeatedly in brucellosis. Literally scores of treatments have been advocated with more or less enthusiasm, but most of them have subsequently been discarded as useless. The evaluation of experimental therapy in any disease is not easy, but in brucellosis the multitudinous symptoms, the well known diagnostic difficulties, and the variable and unpredictable course of the disease all serve to render judgment of therapy exceptionally difficult.

The history of the use of the sulfonamides in brucellosis well illustrates the pitfalls which may be encountered in evaluating therapeutic agents. Following the appearance of two papers in 1936 describing the early sulfonamides as effective drugs in brucellosis, thirty-one reports were published during the next two and one-half years.[8] With but one exception, all were favorable to the efficacy of these drugs in brucellosis. It was two and a half years before the first unfavorable report was published, and it was eight years before a review appeared in which it was concluded that "there is no evidence at the present time that sulfonamides are of enough benefit in the treatment of human brucellosis to warrant their use."[9] This view is generally held today. A somewhat similar story could be told for streptomycin and for many other forms of treatment. When a new drug is introduced, it is apt to be hailed enthusiastically in early papers. Many years may be required to rectify the widespread misinformation when the early reports are of uncritical and poorly controlled observations.

This background on the hazards of appraising therapeutic measures in brucellosis is a necessary introduction to the consideration of the newer forms of therapy which are being widely recommended.

The Huddleson Sulfadiazine-Blood Transfusion Treatment.—The combination of sulfadiazine with transfusions of normal whole blood or fresh plasma has been shown by Huddleson[10] to have a marked bactericidal action against brucella by in vitro and in vivo laboratory studies. The sulfonamide is said to combine with the normal antibody-complement system to produce a highly active complex. Only small doses of sulfadiazine (0.25 Gm. every four hours) are necessary. One or more transfusions are given and the drug is then continued for seven to fourteen days. Dehydrated or lyophilized plasma is not suitable. This treatment is said to have been effective in patients with brucellosis, but the total experience has been too limited to warrant final judgment. The usual hazards of any transfusion are, of course, present with this treatment.

The Combined Streptomycin-Sulfadiazine Treatment.—It has been shown independently by Pulaski and Amspacher[11] and by Eisele and McCullough[12] that the simultaneous administration of streptomycin and sulfadiazine promptly and dramatically terminated the disease in cases of severe brucellosis with prolonged septicemia in which the previous use of each drug alone had been without effect on the fever, symptoms, or bacteremia. This may be considered to be the first really specific treatment for brucellosis. The clinical effectiveness of this combination of drugs has now been widely confirmed.[13-19] The reported cure of 2 patients presumed to have brucella endocarditis, a complication which has heretofore been invariably fatal, strongly supports the effectiveness of this treatment. However, relapses or failures have occurred in a small percentage of the treated patients even when the full recommended course was used.

The possibility of serious drug toxicity sharply limits the usefulness of the combined streptomycin-sulfadiazine treatment. Several cases have been

reported[20] in which widespread central nervous system disturbances of an alarming nature occurred shortly after the onset of treatment. We have repeatedly recommended that this treatment should be reserved for the patient who is seriously ill and incapacitated in whom some risk is justified. The newer dihydrostreptomycin appears to obviate some of the dangers of toxic reactions and should be used in all instances. Daily doses of 2 Gm. of dihydrostreptomycin should be continued for a minimum of fourteen days, and sulfadiazine (usually 6 Gm. per day) should be started a few days before and continued for one or two weeks after dihydrostreptomycin.

Chloromycetin and Aureomycin.—In the current enthusiasm for chloromycetin and aureomycin, several reports have described both drugs optimistically as effective agents in brucellosis.[21-23] A prompt remission of fever and symptoms occurs quite regularly with either drug, but, unfortunately, most of the published cases have been followed insufficiently to warrant a statement as to possible relapse or cure. Already, scattered oral reports have suggested a considerable relapse rate even with large doses. One patient relapsed clinically and bacteriologically soon after a course of aureomycin with daily doses of 12 and 8 Gm. and a total dose of 105 Gm. in twelve days.[24] In 1 of our patients treated with chloromycetin, daily blood cultures continued to be positive throughout a fourteen day course of treatment although the drug reached blood levels of ten to twenty times the concentration which inhibited the patient's organism in the test tube. Subsequent to the treatment, the patient had a spontaneous remission without relapse in more than a year.

Both aureomycin and chloromycetin should be considered to be in the experimental stage for the treatment of brucellosis. Perhaps treatment for periods longer than the usual ten to twenty days may reduce the relapse rate, although at present no evidence exists to support this possibility. Whether either drug is effective in chronic brucellosis is not known, but the meager evidence at hand suggests that neither is effective.

Several facts should temper one's expectations of both aureomycin and chloromycetin. Their in vitro effects are primarily bacteriostatic instead of bactericidal, and they are quite inferior to the effects of combined streptomycin and sulfadiazine. In well controlled experiments on laboratory animals, the effectiveness of both aureomycin and chloromycetin was less than that of combined streptomycin-sulfadiazine.[25] In the treatment of naturally infected cows with large doses of aureomycin, the excretion of brucella in the milk recurred promptly after cessation of treatment in every instance.[26]

The combined use of aureomycin and dihydrostreptomycin was reported by Herrell[27] to have produced satisfactory immediate results with prompt cessation of symptoms in 4 patients. Following in vitro tests in our laboratory, a combination of aureomycin, dihydrostreptomycin, and sulfadiazine successfully terminated a recurrent infection in 1 patient who had previously received in succession treatment with Huddleson transfusion-sulfadiazine treatment, chloromycetin, aureomycin, and combined streptomycin-sulfadiazine, and he had relapsed clinically and bacteriologically following each.[28]

Although all of the current treatments are effective in some cases, none are successful in all. The treatment of the patient with brucellosis must be highly individualized and must include general supportive measures as well as presumably specific treatment. The importance of bed rest should not be minimized, regardless of the type of treatment used. Many patients with acute brucellosis have recovered promptly and completely with bed rest alone, and it is a most valuable adjunct to any form of treatment.

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Brucellosis in Wisconsin*

By A. R. ZINTEK, M. D.
Madison

A. R. ZINTEK

Doctor Zintek, a 1934 graduate of the Marquette University School of Medicine, interned at Milwaukee County Hospital and did three years of graduate work in epidemiology at the University of Michigan to earn the degree of D.P.H. in 1947. From 1945 to 1947 he was a resident lecturer in epidemiology and a research assistant in poliomyelitis at the University of Michigan. He joined the Wisconsin State Board of Health in July 1947 as director of the Bureau of Preventable Diseases.

THE problem of the occurrence of brucellosis is important because it represents a cause of protracted morbidity in man, the magnitude of which cannot be estimated even today. As such, it is of interest to physicians because of the many difficulties encountered in diagnosis and treatment of a disease which may simulate many acute and chronic conditions, and is characterized by relapse almost regardless of the therapy schedule used. The economic aspects of brucellosis add significance. Not only the interval of time lost from work, but its occurrence in domestic animals results in a serious loss of milk and cream production, the loss of many replacements for the herd, and the not infrequent loss of valuable animals. The incidence of brucellosis among our dairy herds here in Wisconsin has been of considerable concern in the interstate shipment of milk to other areas.

The disease is interesting because it is another example of Theobold Smith's hypothesis of aberrant parasitism. The cow, hog, and goat act as excellent reservoirs of infection, with the organism passing from one to the other almost at will. However, the organism is not at all fastidious in its choice of host and will pass to other domestic and wild animals or even man when the occasion arises. Man plays a relatively unimportant part in the continued propagation of brucella, and when he does become the host, it is only occasional and purely accidental in its cycle of reproduction.

Since 1934 more than seven million cattle in the state of Wisconsin have been tested by the Wisconsin State Department of Agriculture. Their work indicates that about 20 to 30 per cent of all herds and some 5 or 6 per cent of all cattle tested are at the present time infected with Bang's disease. This incidence of infection in a natural animal reservoir

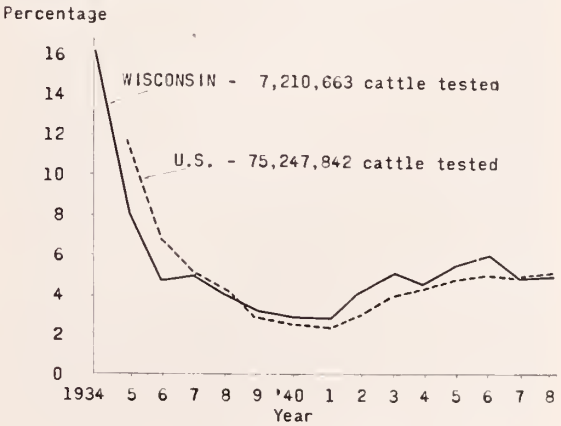

Fig. 1.—Percentage of reactors found in testing for brucellosis in United States and Wisconsin, 1934–1948.

*Read before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

showed a steady decline up to about the year 1941 (fig. 1). During the war years it showed an increase, and since the war it has remained at a relatively stable plateau. The increase during the war years was said to be attributed to a lack of funds, a lack of personnel and difficulty encountered in securing cooperation from farmers at a time when beef and milk products were in very great demand, and selling at a relatively high price. It is believed that a stabilization in economics will again favorably influence the incidence of Bang's disease among Wisconsin cattle.

Brucellosis in man first became reportable in 1929. Since that time, each succeeding year has seen an increasing number of cases reported to the State Board of Health (table 1). The increase was gradual until about 1942, when the trend took a marked upswing. It is believed that this marked increase in 1942 is the result of the State Laboratory of Hygiene inaugurating a program whereby all blood specimens submitted to the laboratory were routinely subjected to a battery of agglutination tests, including an agglutination test for brucellosis. This trend increased to a peak in 1947, when 451 cases were reported. There was a decline in reported cases for the first time in 1948. It is believed that this decrease is only apparent and coincides with the adoption of a more rigid policy in setting criteria for the reporting of clinical cases.

TABLE 1.—*Undulant Fever*

Year	Cases	Deaths
1929	42	
1930	83	1
1931	71	1
1932	59	1
1933	104	2
1934	86	5
1935	89	3
1936	106	4
1937	94	4
1938	79	1
1939	102	0
1940	114	2
1941	130	1
1942	158	3
1943	178	2
1944	241	2
1945	275	3
1946	384	3
1947	444	4
1948	302	

It is difficult to arrive at a reliable estimate of the extent of brucellosis in the human herd. Reported cases are valuable only as an index of recognition. They tell us nothing about the many individuals who are unable to do a full day's work but are not sick enough to present themselves at a physician's office. They do not indicate the many persons who are placed in the category of a neurosis as a result of a chronic recurring brucella infection. Using the skin test as an index of exposure to this specific infection, it is possible to show that more than 25 per cent of the adult population in certain rural areas of the state have at some time during their lives been exposed to the brucella antigen and that hypersensitivity to it has developed in them. With such evidence, Huddleson and Evans have estimated that the true incidence of the disease is about ten times as great as reported cases.

More frequent recognition of the disease will result from an attitude of constant suspicion—a suspicion that should always be ever present, particularly among rural people. A suspicion based upon clinical evidence becomes a diagnosis when it is confirmed by a significantly high agglutination titer, particularly if this titer increases as the patient goes into convalescence, or by a positive blood culture. The skin test is of little value in arriving at the diagnosis of an active infection except insofar as it calls attention to past exposure to the brucella antigen and arouses suspicion which needs confirmation by the laboratory.

The reports of typing by the State Laboratory of Hygiene in ninety consecutive positive blood cultures (table 2) showed that all but 4 persons were infected by the bovine variety of Brucella. Only 2 persons were infected by the melitensis variety and two by the porcine variety. This is a marked variation from the results reported in Iowa, where a majority of the infections resulted from porcine strains. Perhaps this variation is not surprising in view of the fact that Iowa is a hog-raising state, and there the hog acts as the principal reservoir. In contrast to this, the cow in Wisconsin, a dairy state, acts as the chief reservoir.

TABLE 2.—*Type of Isolation from Culturally Proved Cases of Brucellosis 1946 through 1948*

	Total Cultures	Total Positive Cultures	No. of Patients	Abortus Strains	Suis Strains	Melitensis Strains
1946–47	2400	34	34	32	1	1
1947–48	4496	34	28	28		
1948	1542	39	28	26	1	1
	8437	107	90	86	2	2

In no instance has it been possible to demonstrate human infection from the X19 strain currently used to vaccinate cattle and shown to be excreted in the milk in a limited number of instances.

The county distribution of brucellosis among cattle forcefully calls attention to the widespread distribution of the infectious agent. It will be observed (fig. 2) that in some areas of the state, such as south central Wisconsin, the Fox River Valley, and west central Wisconsin, as much as 50 per cent of all herds are infected. It indicates that at least in these areas half of the rural population are frequently exposed to the infection and are potential candidates for development of the disease. It strongly suggests that a diagnosis of brucellosis should be considered in rural patients who present themselves with symptomatology consistent with the disease. The area of relatively clear counties across the northern portion of the state represents, at least to a degree, the success of the control program.

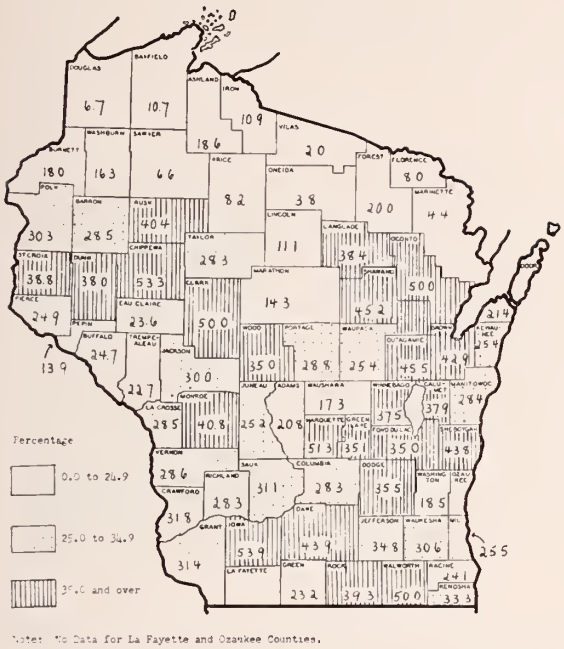

Fig. 2.—Percentage of herds infected with brucellosis, Wisconsin, 1949.

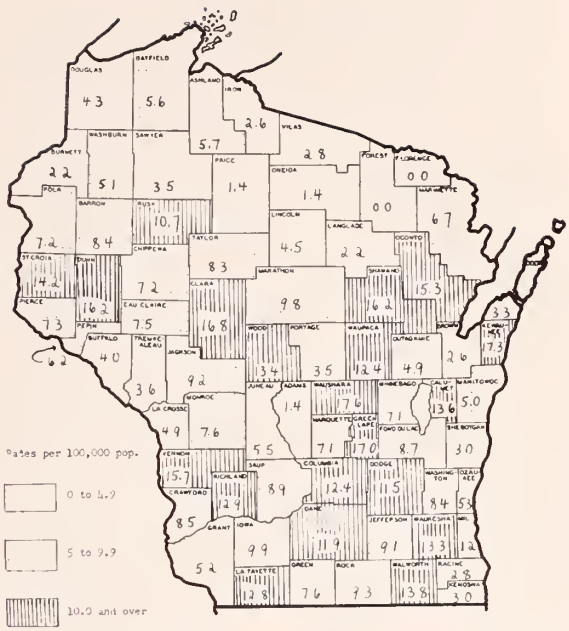

Fig. 3. Brucellosis morbidity rates by counties, Wisconsin, 1939–46.

A majority of the designated accredited areas occur in the northern portion of the state. Paradoxically, because dairying is not as congested in this area, the herds are smaller, and the economic impact has not been as great, it has been easier to initiate control measures among northern herds than has been possible in the southern portion of the state.

In general, morbidity rates among the human herd parallel those found in cattle (fig. 3). Incidence in the northern counties is relatively less than in the remainder of the state. Although the correlation is not entirely uniform, it can be observed that counties in south central, east central, and west central Wisconsin contribute relatively more than other areas of the state.

Control practices in brucellosis will depend eventually upon the ultimate eradication of the disease in domestic farm animals. Insofar as this successful accomplishment still awaits future development, our present control practices must be directed toward isolated segments of cases in which we do have the ability to exercise preventive measures. The risk of developing clinical disease among veterinarians, meat packers, and farmers who handle animals is so high that protective measures to avoid exposure deserve more attention than they have received.

Various estimates have been made as to the number of cases in which the disease has been contracted from drinking raw contaminated milk. Guilford, in a study based on histories obtained, concluded that in 60 per cent of all cases which occurred in Wisconsin the patients gave a history of having consumed raw milk either regularly or at least upon occasion, and assigned 60 per cent as the upper limit of milk-borne infection. Other investigators have estimated that approximately 20 per cent of the cases could be traced to consuming contaminated milk. Many milk-borne epidemics are documented in the literature, the authenticity of which remain unchallenged.

However, the age-sex distribution of reported cases (fig. 4) suggests that contact with animals rather than consumption of contaminated milk is more frequently responsible for the disease in man. It can be observed that in more than 4 out of 5 cases the disease occurs in males and that in the vast majority of cases the disease occurs after the individual has reached the age of 20. This age-

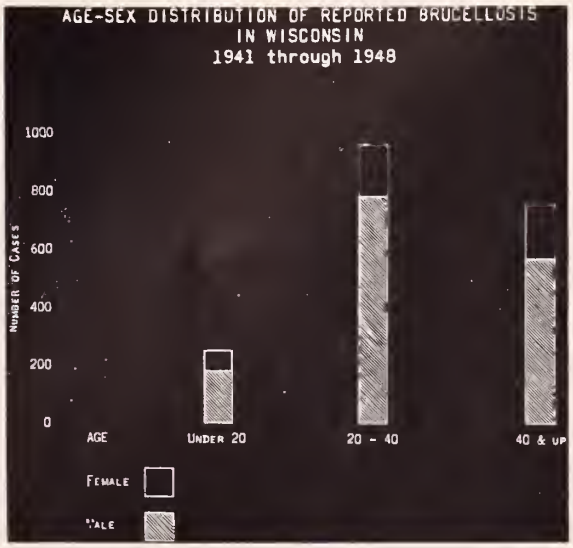

Fig. 4.—Age-sex distribution of reported brucellosis in Wisconsin, 1941–1948.

sex distribution retains the same characteristics when one analyzes only culturally positive cases. It is believed that such a distribution of cases would be a bizarre picture in a disease frequently transmitted through milk, where one expects children to consume most of the milk and therefore to be most frequently exposed. This, however, does not preclude the possibility that brucellosis may be a disease only infrequently diagnosed in children, or perhaps it represents a situation in which persons are relatively insusceptible until they have reached sexual maturity and then are able to readily acquire significant clinical infection. This is not unlike the situation which occurs among cattle. The young calves are relatively insusceptible until they have reached sexual maturity. Possibly, clinically significant infection could represent a pathogenesis similar to reinfection tuberculosis where the original exposure occurs early in life, but significant disease is not noted until the person reaches maturity. However, analysis of the age distribution of cases in milk-borne epidemics suggests that in these instances selectivity is limited predominately to the milk drinkers, that is, the children at a relatively young age. This distribution of cases, plus the fact that brucellosis is essentially found among agriculture people, calls attention to a disease, primarily one of adult rural males, which must be suspected in non-urban people who present themselves to a physician with a rather indefinite illness of a chronic nature.

However, the fact remains that at least a portion of the total number of cases occur from consuming contaminated milk, and a uniform state-wide pasteurization law could materially reduce this incidence. One should not be misled into believing that our present state-wide pasteurization law with its serious limitations in permitting the sale of raw milk under certain circumstances will bring about such an accomplishment.

In conclusion, your attention is called to the facts that (1) the incidence of brucellosis is difficult to estimate, but its occurrence is sufficiently frequent to make it a serious problem in human morbidity; (2) the diagnosis should be suspected particularly among rural people who present themselves with ill defined symptoms; (3) a uniform state-wide adequate pasteurization law would contribute to materially reduce the incidence of this disease.

WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION TO MEET MAY 9-11

Heading the list of medical speakers at the forty-second annual meeting of the Wisconsin Anti-Tuberculosis Association will be Dr. Harry A. Wilmer, of Palo Alto, Calif., Clinic. Doctor Wilmer is the author and illustrator of several books, including "Huber The Tuber," an extremely popular and successful book about the tubercle bacilli.

This year's WATA meeting, which annually attracts to Milwaukee hundreds of nurses, teachers, social workers, doctors, and volunteer workers from all over Wisconsin, will be held on May 9, 10, and 11 at the Hotel Schroeder. The Trudeau Society, which holds its meeting in conjunction with the WATA Annual Meeting, will meet the first day, May 9.

A special attraction at this year's meeting will be a television show, featuring an actual "on the spot" fluoroscopic lung examination. As far as is known, this has never been done before; the audience will have a ring-side view on the screen of the doctor examining a person's lungs.

Doctor Wilmer will discuss the emotional aspects of tuberculosis. Other speakers will be Dr. A. R. Zintek, Wisconsin State Board of Health; Dr. M. C. Thomas, manager, Waukesha Veterans Administration Hospital; Dr. W. D. Stovall, Wisconsin State Board of Public Welfare; Mr. Sydney B. Markey, director, Milwaukee County Survey of Social Welfare and Health Services; Dr. John D. Steele, president, Mississippi Valley Trudeau Society; and Dr. E. R. Krumbiegel, health commissioner, city of Milwaukee.

Cerebral Angiography*

By R. W. BYRNE, M. D.
Milwaukee

R. W. BYRNE

Doctor Byrne has been an associate radiologist at Columbia Hospital, Milwaukee, since 1948. A graduate of the University of Michigan Medical School in 1940, he served a rotating internship at the University Hospital, Ann Arbor, Mich. Following four years in the Army Medical Corps, he returned to Ann Arbor to complete a three year residency in radiology. The doctor is certified by the American Board of Radiology.

THE rapid and extensive development of intracranial surgery has been a challenge to the radiologist to aid, as far as possible, in the diagnosis of intracranial lesions prior to direct surgical exploration. Several diagnostic x-ray procedures have been developed.

The simplest of these procedures is the routine examination of the skull. Abnormal intracranial calcification, bone erosion or invasion, or displaced, so-called, physiologic, calcifications are the clues to intracranial lesions.

Intracranial air studies, encephalography, and ventriculography are sometimes indicated. Displacement, deformity, enlargement, or invasion abnormalities of the air-filled ventricular system may be seen when lesions are present within the calvarium.

The last and most recently developed procedure is that of cerebral angiography, first introduced and described by Egas Monez of Lisbon in 1927.

By cerebral angiography we mean the perfusion of a radio-opaque material into the intracranial vascular system. Either by percutaneous injection of the carotid or vertebral artery or by incision and injection of the exposed carotid or vertebral artery with either diodrast or thorotrast, the intracranial ramifications of the chosen vessel are rendered momentarily densely opaque on an x-ray film if one is taken at the exact time of complete fill of the vascular system. The procedure is done with the patient under general anesthesia and requires exact timing between the injection and the exposure of the film.

The procedure is not without danger. The injection should probably be done only by a neurosurgeon, and in his hands mortality or morbidity should be almost nil.

Diodrast and thorotrast have been commonly used. If diodrast is used, the problem of sensitivity must be considered, and if thorotrast is used, the dangers of using a radioactive agent must be also considered.

Intracranial angiography and intracranial pneumography are not rival or competitive procedures.

*Read before the One Hundred and Eighth Annual Meeting of the State Medical Society, Milwaukee, October 1949.

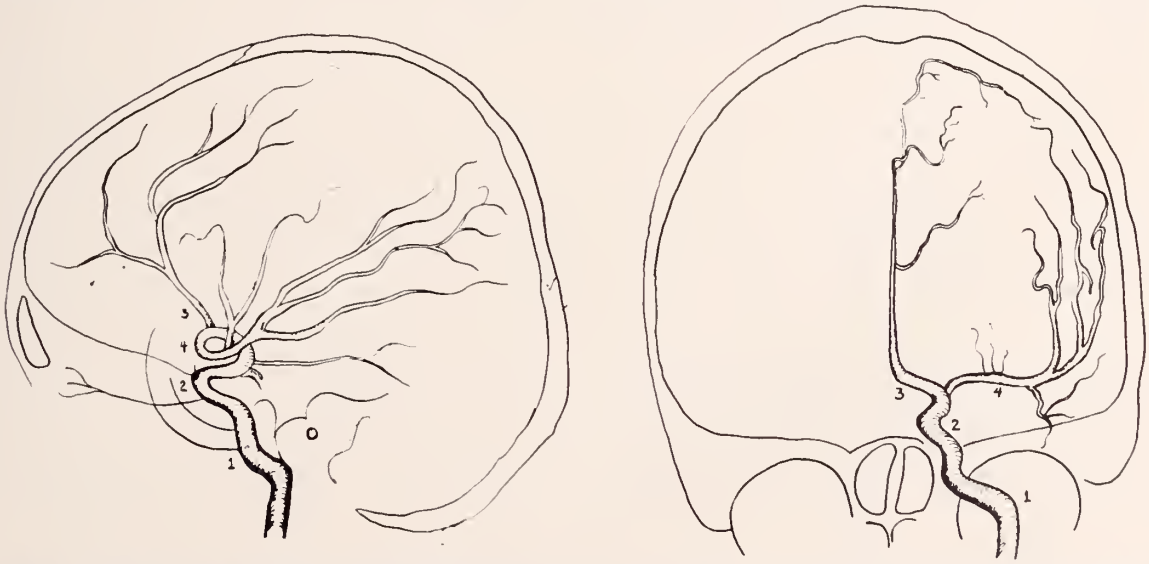

Fig. 1.—Diagram of a normal internal carotid artery arteriogram: *1*, internal carotid artery; *2*, carotid siphon; *3*, anterior cerebral artery; *4*, middle cerebral artery, its three main branches roughly follow the sylvian fissure. (Note the numerals given here correspond to the same vessels in all of the illustrations used.)

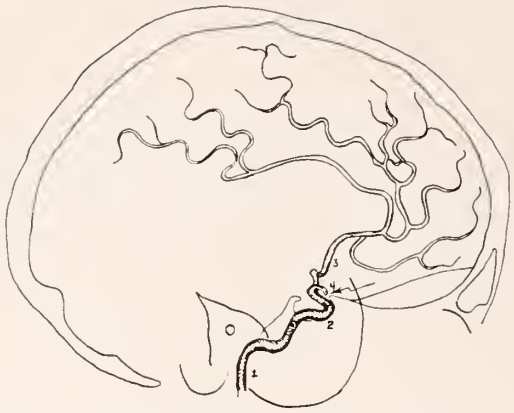

Fig. 2.—Complete occlusion of the middle cerebral artery and all of its branches. The arrows point to the site of occlusion (patient aged 43).

One or the other method may be indicated, and in a few cases both methods may be necessary. Angiography is inferior to pneumography in cases of increased intracranial pressure without definite localizing signs, and in cases of tumors of the ventricular system, midbrain or basal ganglia. Angiography is superior to the air studies in cases of space-occupying lesions of the cerebral hemispheres when it is known on which side the lesion is, and in vascular lesions of the brain. If a vascular malformation is suspected, angiography should be the procedure of choice.

The following diagrams traced from actual cases demonstrate some of the various types of lesions diagnosed by angiographic methods. The appearance of the normal cerebral arteriogram is shown (fig. 1*A* and *B*). Angiographic diagnosis depends on a knowledge of the normal vascular pattern so that any deviation from normal may be correctly evaluated. It is seen that the branches of the internal carotid artery supply the entire cerebral hemisphere.

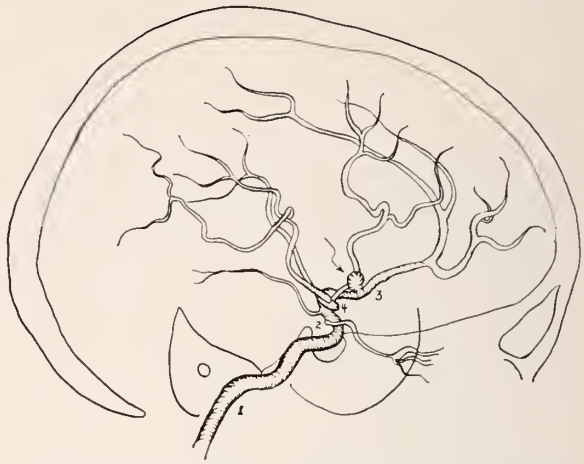

Fig. 3.—Solitary congenital aneurysm of the anterior cerebral artery near its origin. The arrow points to the small sacular aneurysm (patient aged 21).

Vascular abnormalities within the brain may be divided into various types which are actually visualized upon the film. They consist of (1) vascular occlusions, (2) aneurysms, (3) arteriovenous fistulae, (4) vascular tumors, and (5) space-occupying lesions of subdural or epidural hemorrhages.

A complete vascular occlusion of the middle cerebral artery and all its branches is shown (fig. 2).

Aneurysms (fig. 3) may arise anywhere within the calvarium.

Cavernous sinus arteriovenous fistulae are usually traumatic in origin. Usually they are readily identified by angiography.

Intracranial angiomata are also readily visible by angiography. They consist of a tangle of large arteries and connecting veins (fig. 4). Visualization of venous pathways in the arterial phase is due to

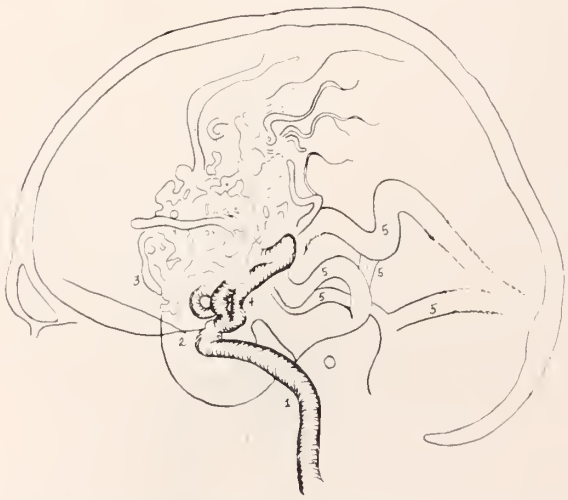

Fig. 4.—Large angioma. No. 5 demarks the visible venous sinus pathways of the brain made visible by a mechanism peculiar to this condition and described in the text.

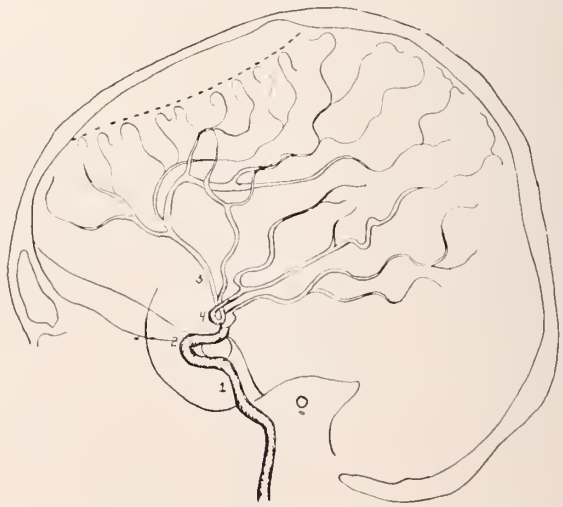

Fig. 5.—Epidural hemorrhage, traumatic, following a large sagittally projected linear skull fracture. Note the smooth downward displacement of the cortex of the brain by the hematoma and made visible because of the filling of the surface vessels of the brain.

the numerous arteriovenous fistulae present with resultant reduction in resistance of blood flow.

An epidural hemorrhage resulting after a linear skull fracture may be seen by cerebral angiography (fig. 5). The extent of the hematoma is demonstrated by the visualization of the surface of the brain by the filling of the small cortical vessels. A similar picture would be seen if this were a subdural hemorrhage.

Neoplasms of the brain and other space-occupying lesions are shown on arteriograms by deformities of the intracranial vessels caused by the mass. These vascular changes may be (1) displacement of the vessels, (2) straightening and stretching of the vessels so that they no longer follow their normal tortuous course, (3) thinning of the vessels, and (4) visualization of the delicate, abnormal vessels of the tumor itself which in some cases may be suggestive of a definite tumor type.

A large space-occupying lesion in the parietal region (fig. 6*A* and *B*), which proved to be a large glioblastoma at operation, shows all of the resultant vascular abnormalities listed.

Summary

1. Cerebral angiography is a valuable method to aid in the diagnosis of intracranial pathology in selected cases.

2. Typical examples of various lesions are presented.

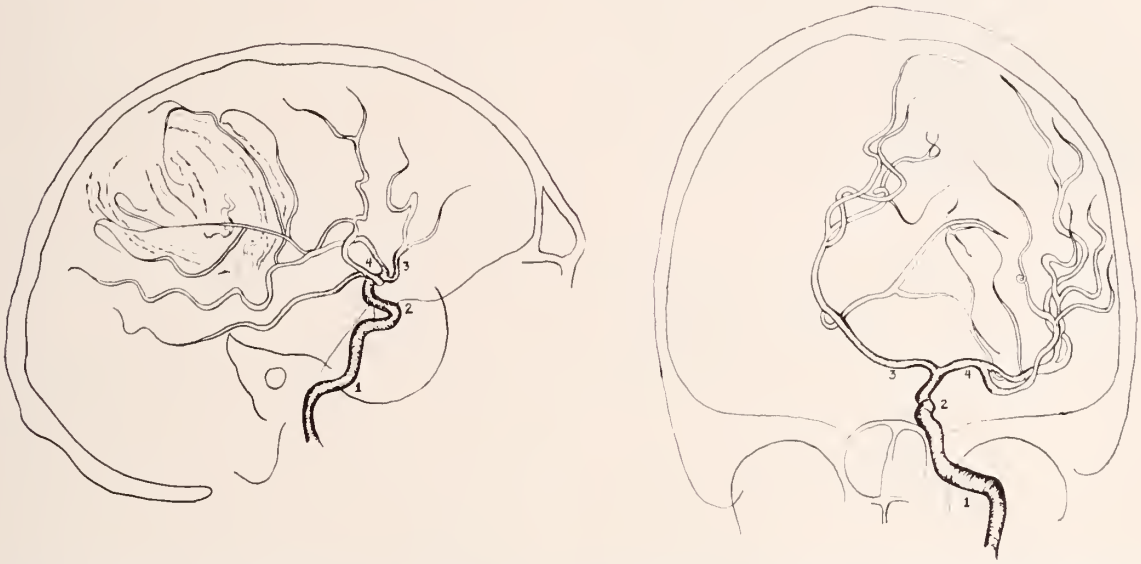

Fig. 6.—Glioblastoma multiforme, parietal, with considerable associated edema. Note the displacement of the anterior cerebral artery across the midline in frontal projection and the visualization of the tumor because of its abnormal blood supply in lateral projection.

AMERICAN COLLEGE OF CHEST PHYSICIANS OFFERS ESSAY AWARD

The Board of Regents of the American College of Chest Physicians is again offering its annual cash prize award of $250 for the best original contribution, preferably by a young investigator, on any phase of chest disease. The winning contribution will be selected by a board of impartial judges, and the first award will be made at the forthcoming annual meeting of the College, to be held in San Francisco, June 22–25.

The following conditions must be observed: (1) Five copies of the manuscript, typewritten in English, should be submitted to the American College of Chest Physicians not later than May 1. (2) The only means of identification of the author or authors shall be a motto or other device on the title page and a sealed envelope, bearing the same motto on the outside, enclosing the name of the author or authors. Additional information may be obtained from the Executive Secretary of the College, 500 North Dearborn Street, Chicago 10, Illinois.

Tuberculosis Control Programs Among School Personnel

By A. A. PLEYTE, M. D. and KENNETH POMMERENCK
Milwaukee

A. A. PLEYTE

Doctor Pleyte, a graduate of Marquette University School of Medicine, has been director of the medical department of the Wisconsin Anti-Tuberculosis Association since 1939. A diplomate of the American Board of Internal Medicine, he is a member of the American College of Physicians, the Wisconsin and American Trudeau societies, and the Wisconsin and American Public Health associations.

IN THE May 1946 issue of *The Wisconsin Medical Journal*, one of us outlined a suggested program for controlling tuberculosis among school employees.[1] It was suggested that (1) educational campaigns for the prevention of tuberculosis be actively supported by the State Medical Society; (2) periodic examinations be made of teachers and other school employees; and (3) permissive legislation be adopted making it possible for school boards to expend necessary monies for physical examinations, including a chest x-ray film annually for all school personnel. These suggestions were in line with recommendations by the Committee on Tuberculosis of the American Association of School Physicians.

A year later, the third of these goals was reached. In 1947, the Wisconsin legislature passed a law permitting school boards of districts in counties of less than 500,000 population (all counties except Milwaukee) to require, as a condition of employment, periodic health examinations of all school employees except those objecting on religious grounds. The law also states that the cost of such examinations, including x-rays, shall be paid from district funds.

The need for such legislation has long been apparent. Many cases have been known to the Wisconsin Anti-Tuberculosis Association through the years in which it appears that teachers or nonteaching personnel have transmitted tuberculosis infection to their pupils. Teachers are still leaving our schools for sanatoriums with active tuberculosis and positive sputum. Examples of tuberculosis infection of serious proportions are still coming to light in some of our schools.

For instance, in one Wisconsin school a teacher was found to have advanced disease and died a short time after the condition was diagnosed. About 80 per cent of the students in this school reacted to the tuberculin skin test, and within a few months, 3 students are known to have entered sanatoriums, 1 with advanced disease.

In the year from August 1948 through July 1949, 7 teachers, 2 janitors, and 1 cafeteria employee are known to have entered Wisconsin sanatoriums. In 6 of these cases the disease was in an advanced stage: in 2 the disease was diagnosed far advanced on admission and in 4 others, moderately advanced. Six of the 10 patients entered the sanatoriums during the months of May, June, and July—in other words, at the end of the school year—which suggests that the children in their schools may have been exposed to infection for several months.

What progress has been made in meeting the problem? Particularly, to what extent do school boards utilize this permissive legislation?

The answer may be seen in a study by the Wisconsin Anti-Tuberculosis Association to determine the quantity and quality of tuberculosis control programs among Wisconsin school personnel.

Questionnaires were sent to 560 superintendents of schools in counties or cities, high school principals in smaller communities (hereafter referred to as "villages"), and directors of vocational schools. After the initial letter and a follow-up reminder, 420, or 75 per cent, of the questionnaires were returned.*

In the matter of returns, the county school systems showed the best response, returning 86 per cent of the questionnaires. The city schools were next with 83 per cent. The village systems showed a 72 per cent response, and the vocational schools 56 per cent. Most of the material that follows will be based on the city, village, and vocational school returns, since the county questionnaires were necessarily worded differently. From these city, village, and vocational schools we have 357 answers for consideration.

We may first view the results of the study by considering the answers given to individual questions.

1. *Are all applicants for employment required to furnish evidence of freedom from active tuberculosis?*

   Teachers: Yes No

   NonTeachers: Yes No

* The 420 questionnaire replies upon which these findings are based were sent to the Wisconsin Anti-Tuberculosis Association between August 1948 and the spring of 1949. Scattered replies have been received since, and some improvement in programs has been reported. On the other hand, spot checks of certain communities suggest that the programs in actual practice may not always be as complete as reported.

Of the 357 school systems (excluding county school systems), 59, or 16.5 per cent, answered "Yes" and 262, or 73.4 per cent, answered "No," for both groups, teachers and nonteachers. Some other answer was given 36, or 10.1 per cent. This category includes systems which state that only teachers or only nonteachers were required to have examinations, or systems replying for teachers only, or systems not answering this question at all.

2. *Are all regularly employed persons required periodically to furnish evidence of freedom from active tuberculosis?*

Teachers: Yes No

NonTeachers: Yes No

Here 67, or 18.8 per cent, of the school systems answered "Yes" and 227, or 63.6 per cent, answered "No." There were 63, or 17.6 per cent, which gave some other answer. These answers fell into groups similar to those referred to above.

For the two most significant questions in the survey, then—that is, whether applicants and routinely employed personnel are required to furnish evidence of freedom from active tuberculosis—less than one-fifth of the school systems replying gave an affirmative answer. Going on to the other questions, we find:

3. *How often is this evidence required?*

Such evidence is required annually from all employees by 12.6 per cent of the school systems.

4. *Who pays for these examinations?*

The legislation passed in 1947 provides that examinations may be required by school boards and if required they shall be paid for from district funds. But from the survey, it appears the school board pays for the examinations in only 6.7 per cent of the school systems.

5. *Are the specified requirements written into the employment contracts?*

In 5.6 per cent of the school systems the requirements are in the contracts for all employees.

So far we have dealt with the individual questions and the percentage which the "most desirable" answers formed of the total. We can look at the results from another point of view and see what types of over-all programs are in effect in individual school systems.

Only nine school systems (exclusive of county systems) appear to have really good programs. These systems require both applicants and regular employees, teachers and nonteachers alike, to furnish evidence annually of freedom from active tuberculosis, including skin tests and x-rays or fluoroscopic examinations, and have this requirement in the contract for all personnel.

An additional thirty-six school systems have fairly adequate programs. They require both applicants and employees, teachers and nonteachers alike, to furnish periodic evidence of freedom from active tuberculosis. The period of time between examinations in this group is two years, three years, or unstated. For most the requirement is either not written into the contract or is in the contract for teachers only. For most of those that do not have the requirement in the contract there is no indication of how it is enforced.

There are fifty-seven other school systems that have some type of program, but they can only be described as poor. These have time intervals of one, two, three, four, or five years between examinations, or require them only "when requested," but in no case are all of the employees included in the program. Some require proof of teachers only, a few of nonteachers only, some of regular employees only, some of applicants only. One excluded bus drivers; one required proof of bus drivers only. Most contracts contain no stipulation.

Of the sixty-two county superintendents replying, only four reported that all applicants and employees are required to furnish evidence of freedom from active tuberculosis. Only one of these four had the requirements in the contract for all personnel. Two of them had the requirements in the teachers' contracts and the fourth had the requirements in some of the teachers' contracts. Requirements of varying degrees were reported by six others. Another had no requirements, but all personnel have been tested this past school year. The remainder either had no requirement or did not answer the question.

Conclusions and Comments

1. While some progress has been made in the number of school personnel receiving an annual or biannual physical examination and in furnishing proof of freedom from tuberculosis, the evidence appears clear that, generally speaking, school programs in this respect are far from satisfactory.

2. There is apparently a wide interest in, or at least an awareness of, the need for health programs for both teachers and non-teaching personnel. This is evidenced in part by the high percentage of questionnaires returned, and in part by the large number of comments as to what particular schools are doing.

3. At present, only nine school systems (exclusive of county systems) report having good tuberculosis control programs for both teachers and nonteaching personnel, and only thirty-six others may be considered to have reasonably adequate programs. There remain, then, three hundred and twelve school systems among those reporting which either have no program or whose programs might conceivably work well in some phases, or at some specific time, but for whom there is certainly no long-term assurance of protection for employees or students.

4. One-half of those not having any requirements seem to encourage voluntary use of facilities if and when available (as, for example, when mobile x-ray equipment of the State Board of Health or the Wisconsin Anti-Tuberculosis Association is near at hand). With such an awareness of the need for a

program of this type, the next logical step would seem to be overcoming the apparent reluctance to put it on a required basis.

5. Rural school systems, as may be expected, lag in this program. It is obviously more difficult to organize and administer such a plan on a rural, county-wide basis then it is in a more integrated city or village system. It seems particularly significant, therefore, that the three counties with the best programs are all in the northern part of the state, where geographic and economic factors are unfavorable.

6. Very few schools take advantage of the legislation which permits the financing of examinations through the school board. Fear of opposition from teachers to a required program probably stems from the realization that the teachers would object to being held responsible for the cost. Utilization of the measure provided by the 1947 Legislature furnishes a practical answer to this problem.

7. We believe that county medical societies and individual physicians can do much to: (*a*) encourage the use of our existing law for examination of school personnel and students; (*b*) educate teachers and the lay public on the necessity for freedom from infectious disease in our schools; and (*c*) activate an adequate health program in their county or community.

REFERENCE

1. Pleyte, A. A.: Physical examination of school employees with special reference to tuberculosis, Wisconsin M. J. 45: 497–500 (May) 1946.

BUREAU FOR HANDICAPPED CHILDREN ANNOUNCES DATES OF ORTHOPEDIC FIELD CLINICS

The Bureau for Handicapped Children of the State Department of Public Instruction recently announced the dates for the orthopedic field clinics to be held during the first half of 1950. The clinics are conducted by the Division for Crippled Children for persons under 21 years of age who come within the state's definition of a crippled child.

It is preferred that referrals be made by the family physician, but when this is not feasible, arrangements may be made by writing directly to the Bureau. Unless otherwise directed, forms for referral may be obtained from the Bureau and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons to be examined, so that the required personnel may be made available. Families who return the signed form will be notified of their hour of appointment a few days before the clinic.

Parents and physicians are invited to attend the clinic with the child. If the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau is interested in knowing of this in advance.

The cities and dates are as follows:

Manitowoc	March 29–30
Wausau	April 5 (tentative)
Marinette	April 12
La Crosse	April 19–21
Sheboygan	April 27–28
Appleton	May 4, 5
Superior	May 12
Fond du Lac	May 18, 19
Kenosha	May 24, 25
Chippewa Falls	June 8, 9

Correspondence concerning the clinics should be addressed to the Bureau for Handicapped Children, 146 North, Capitol, Madison 2, Wisconsin.

The Procedures and Results of the Philadelphia Committee For the Study of Pelvic Cancer*

By JOHN Y. HOWSON, M. D.
Philadelphia

J. Y. HOWSON

Chairman of the Philadelphia Committee for the Study of Pelvic Cancer, Doctor Howson is an associate in obstetrics and gynecology at the medical school of the University of Pennsylvania. He is also assistant gynecologist to the radiologic department of Philadelphia General Hospital.

THE fundamental purpose of this paper is to arouse interest in a project designed to stimulate the early diagnosis of cancer in the female pelvic organs. The inspiration for the creation of the Philadelphia Committee for the Study of Pelvic Cancer came from two generally accepted facts: First, therapeutic success in pelvic cancer depends on early diagnosis; and second, under present forms of treatment the only chance to increase the cure rate in this disease is to eliminate the now prevalent diagnostic delay period.

The details of the organization of this Committee have previously been described and published.[1] It seems important to review some basic points of procedure and function of the Committee to assure a complete understanding by those of you not intimately familiar with this project.

The problem of early diagnosis of cancer in any site depends on the patient's cooperation and the prompt and appropriate action of the physician. The present discussion is limited to a consideration of the physician's responsibility and a plan to aid in eradicating the many factors affecting him in latent diagnosis.

The Philadelphia Committee was organized as a cooperative effort in which the general practitioner and gynecologist participate, and through which the numerous problems which arise in pelvic cancer diagnosis in the practice of the family doctor are disclosed and solutions earnestly considered. With the modus operandi of the well known maternal welfare committee as a pattern for conducting its activities, the Committee for the Study of Pelvic Cancer felt its greatest contribution could be rendered by having friendly meetings with the general practitioner to discuss the elements of diagnostic delay. The general practitioner was the center of the program because of the important role he plays in this problem. The family doctor is the first one contacted by the patient, and his responsibility is to act promptly and accurately to insure the greatest possible benefit to his patient. As will be noted later, the responsibility is far from limited entirely to the level of the general doctor.

The Committee for the Study of Pelvic Cancer was organized in 1945 by the Philadelphia Obstetrical Society with the approval of the County Medical Society and with the financial support of the Philadelphia Division of the American Cancer Society.

The first step in our activity was to obtain positive evidence of the presence of a diagnostic delay period. The authority for our later objectives seemed to be based on a first hand accumulation of these facts. The work of Pack and Gallo[2] and of Leach and Robbins[3] in 1938 and 1947 respectively along with others have established the presence of delay and the part played in it by the physician. Their work lacked a very vital source of information by failing to include the physician's side of the story. By obtaining this, we hoped to balance the biased facts obtained from the patients or their families.

We began our search for accurate details of the diagnostic delay period by contacting the hospital records, the family physician, and the relatives of all patients registered with the Bureau of Vital Statistics in Philadelphia as having died from pelvic cancer. Little relevant information about dead patients was obtainable. The hospital records, in our experience, did not give a detailed analysis of the sequence of events from the time the symptoms first developed until an accurate diagnosis was made. In the same manner the family of the deceased patient revealed few pertinent facts. The physicians, too, were reluctant to discuss matters relevant to patients they had treated and who ultimately had died.

After two months of this approach, we changed our mode of attack. The living patient was believed to be the only reliable source of information regarding the onset of her illness and of her relationship with her doctor. This approach seemed to pose many problems, the most serious one being that special questioning of a patient along the lines suggested would cause suspicion or disclose to the patient that she was a victim of cancer. Our fears were totally unwarranted.

*Read before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

In December 1945 permission was granted to our investigator to enter the wards and outpatient clinic of the Radiologic Department of the Philadelphia General Hospital for direct questioning of all patients known to have pelvic cancer. From this early beginning the Committee has expanded its efforts to the extent that at present thirty-three hospitals have been incorporated into our program, which means that the Committee's two full time investigators have been granted permission to enter the wards and outpatient clinics. The accuracy of the information obtained and the cooperation of all patients questioned have been very encouraging. In all cases the sequence of events prevailing from the onset of the patient's symptoms until an accurate diagnosis is made is carefully recorded. A delay is considered to exist on the physician's part if more than one month elapsed between the first visit of the patient to the doctor and the establishment of a diagnosis. Similarly the names and addresses of all physicians who have attended the patient, the extent of the examination, the type of treatment given, and advice rendered are duly noted.

After four months of case analysis and with the facts to prove the existence of delay in many cases of pelvic cancer, we set out to accomplish our main objective. We began to invite the physicians of patients where the delay seemed to be his responsibility to convene with the Committee at the monthly discussion meetings. The response by the physicians to these invitations was rather poor at the outset. There did not seem to be any antagonism to the idea behind the meetings; yet the fact remained that there was some hesitancy.

By means of local publicity, persistence, and friendly handling of those physicians who did attend, our problem now is relatively an easy one. To date we have had approximately one hundred and fifty busy doctors who have taken the time and trouble to attend these discussion sessions. The active participation of these physicians in discussing the factors of delayed diagnosis has brought to light many difficult problems that will require considerable thought and effort to correct. An enumeration of many of the discussion points and problems arising at these meetings likewise have been previously published.[4]

These meetings are purposely informal and friendly; yet the dicussions have been serious and stimulating. The physicians who have met with the Committee have been dealt with in a friendly manner and there has been a frank exchange of ideas between the general practitioners and the specialists in gynecology. That a delay occurs in a given instance is subordinated in the discussion to an analysis of why it occurred and how a similar recurrence might be avoided in the future.

The primary purpose of this method of approach is to analyze the reasons behind physician delay, not to be critical of his handling of the patient, but, through an appreciation of his problem, attempt to offer constructive solutions. Actually a very practical educational program for the physician has been activated. It is educational in that the general practioner, as well as all others who are in attendance, is sensitized to the important role he plays in the cancer problem; he is made more "cancer conscious," and open discussion of these problems of delay in cancer diagnosis cannot help but lead to a higher incidence of early diagnosis in this disease.

Having considered the origin and method of procedure of the Cancer Committee, a brief statistical review of pertinent information accumulated in the Committee's records should be reviewed. In presenting these data the writer wishes to emphasize the figures collected have been secured from the patient and from her physician. Heretofore, comparable statistics have been presented from the unchecked, often biased, and inaccurate report of the patients alone. The truth is that the data more accurately confirm the universally recognized and lamented fact of lost time between the appearance of symptoms and the establishment of diagnosis.

To date we have recorded statistics of 1,580 cases. The physician contributed to a delayed diagnosis in 464 instances or 29.4 per cent of the cases.

TABLE 1.—*Proportion of Patient and Physician Delay in 1,580 Cases*

Investigated as of July 1, 1949

	No.	%
Patient delay	656	41.5
Physician delay	230	14.6
Physician and patient delay	234	14.8
No delay	460	29.1
	1,580	100.0
Combined physician delay (230 plus 234)	464	29.4
Combined patient delay (656 plus 234)	890	56.3

The four major sites of cancer in the pelvis were involved in 440 patients. Table 2 illustrates the delay by organs or site.

TABLE 2.—*Delay by Organs or Site*

	Cervix	Fundus	Ovary	Vulva
Total cases	963	364	140	39
Physician delay	27.5%	29.7%	34.4%	48.7%

It is interesting to note that the highest incidence of delay occurs in cancer of the vulva. The small number of cases may effect this figure, but the protracted use of local medicines was the frequent cause of delay in this series.

The average duration of physician delay is illustrated in table 3. An average of seven and four-tenths months elapsed in the case of cervical cancer, in contrast to an average delay of nineteen months for cancer of the vulva.

The major contributing cause for the failure to diagnose cancer before undue delay occurred was the failure to perform a simple pelvic examination.

TABLE 3.—*Average Length of Physician Delay*

	Months
Cervix	7.4
Fundus	13.7
Ovary	9.6
Vulva	19.0

Table 4 demonstrates the incidence of failure to perform a pelvic examination in the four major sites of occurrences of pelvic cancer. The range of incidence varies from 46.3 per cent in the case of fundal cancer to 64.6 per cent in the smaller number of ovarian cancers. This same table further demonstrates the number of physicians involved in failure to examine, there being in some cases two to five physicians.

TABLE 4.—*Delay in Diagnosis Due to Failure to Examine Patients*

	Physician delay	Not examined,		Number of Physicians involved
		No.	%	
Fundus	108	50	46.3	105
Cervix	265	132	49.8	270
Ovary	48	31	64.6	58
Vulva	19	11	57.9	21
	440	224	50.0	454

Time does not permit a detailed enumeration of all the causes of delay encountered. It should be stated that not all of these instances of physician delay occurred among general practitioners. In 39 cases, delay in diagnosis or treatment occurred on services of Philadelphia hospitals. The commonest cause of delay in this group was the performance of inadequate surgical treatment before the presence of carcinoma had been ruled out by appropriate study.

Thus a quick glance at these figures seems to indicate a problem of delay does exist. In 50 per cent of the delay cases it seems that the mistakes were made not through lack of knowledge but through the failure to look for, or think of, cancer as a cause of the patients' symptoms.

Results

In trying to evaluate the effect of this Committee on the early diagnosis of pelvic cancer in Philadelphia we realize at once we have no acceptable measureable success. The only standard for measuring the influence of an effort of this kind would be to compare the incidence of pelvic cancer deaths in Philadelphia County before and after the presence of the Committee. A noticeable reduction in the mortality rate among such cases might indicate that earlier diagnoses were being made. Admittedly the Committee has as yet no such convincing evidence of the value of its activity.

In a serious attempt to evaluate statistically the Committee's influence on the problem of delay, a yearly comparison of the number of cases of physician delay has been made as shown in table 5.

TABLE 5.—*Comparison of Physician Delay by Years*

1946	1947	1948	1949 (6 mos.)	Total
25.5%	27.0%	30.7%	22.1%	26.6%

It was felt that an indication of early progress might be registered if a decrease in the number of cases showing delay could be demonstrated. This would mean, of course, an ultimate decrease in the mortality rate from pelvic cancer. It is noted that in 1946, 25.5 per cent of the cases reviewed indicated physician delay, whereas in 1948 the figure rose to 30.7 per cent. For the first six months of 1949, the percentage dropped to 22.1 per cent. The conclusion is obvious that we are not in a position at the present time to give factual evidence of the value of our efforts. It is consoling to note that during the first five years of the activity of the maternal welfare committee in Philadelphia there was not an appreciable change in the maternal mortality rate of that city.

This is far from discouraging, because it is quite apparent much of our success and influence will be immeasurable from a statistical standpoint. It is most encouraging to be able to report certain influences in our community as the result of the Committee's efforts.

In the first place the monthly luncheon meetings have become an integral part of the educational medical program in Philadelphia. A majority of the Committee members are gynecologic heads of their respective medical schools and in addition have very active private practices; yet with very few exceptions all are regularly in attendance. This factor alone has played a significant role in the Committee's success. The authoritative judgment and the interest of these men have stimulated especially the attendance of residents and interns from hospitals throughout the city. The educational value derived from the discussions at these meetings has led to the often expressed opinion that these sessions are a veritable postgraduate course in gynecologic malignancy. Because of the free discussion of the problems of early cancer diagnosis and because most of the elements of discussion affect all practitioners and specialists, the monthly meeting transactions are published in the county medical society bulletin and are distributed to the society membership. These transactions are read and anticipated monthly by physicians throughout the city.

Significant too is the interest excited among physicians who have attended the meetings. A mailing list is kept whereby those signifying interest are regularly notified of the time and place of the next meeting. Each month some of the general practitioners who have attended the meetings request to

be placed on this mailing list. They have often expressed their belief in the educational value derived from their attendance and wish to further this by becoming regular attendants.

In addition to the influence on individuals of the profession, there seems to have been some favorable reaction in certain respects as regards the hospitals of the city. With very few exceptions the activities of the Committee have not only been accepted but heartily approved and encouraged. It has been our custom to classify instances of delay occurring in hospital patients as institutional delay. When such cases are listed for meeting discussion, the chief of service is notified and he or one of his staff presents the facts for review. It has frequently been apparent that the discussion so presented has been carefully prepared at a staff meeting. The open admission of certain errors leading to delayed diagnosis with recommendations for avoiding future recurrences under similar circumstances embodies the very spirit of this whole endeavor. It has been frankly admitted that some hospital staffs have made deliberate changes in the handling of the cancer patients as a result of Committee recommendations. It is significant that in some instances tumor clinics, cancer follow-up clinics, and orderly files of cancer patients have been instituted since the activation of the Committee for the Study of Pelvic Cancer. It has been found that the lack of adequate supervision of untrained personnel both on the wards and in the clinics has led to gross delay. The adoption of rules for closer supervision of the suspected cancer patient has resulted. The more careful referral of the known cancer case from one department or hospital to another has been given some attention, and we think is becoming more efficient. Some of the teaching schools have made attendance at our meetings an integral part of their resident training program.

Probably the most encouraging indication of the approval of the work of the Committee is the self-expressed desire of many physicians to include their private and semi-private patients in our survey. We began with considerable fear of the reaction we might create in approaching the clinic patient. The problem of reaching the private patients seemed insurmountable. By approaching individuals sympathetic with our aims a slow infiltration into the private floors began. The practice is now widespread and is ever gathering momentum. To date we are proud to admit that not a single unpleasant incidence has arisen.

The favorable acceptance by the general practitioner of this whole approach to the cancer problem must be emphasized. In Philadelphia it has become very evident that this method of attack on the delay period is an acceptable one. From the very beginning the invited guests have been treated with the utmost respect and have been impressed with the idea that the benefits derived from these sessions are helpful to family doctor and specialist alike. The general practitioner's problems have been brought out and the doctor and the Committee have come to grips with them and it is safe to say the family physician has taken away an indelible impression of his importance in early cancer diagnosis. The gynecologist likewise has had re-emphasized his responsibilties in treatment and follow-up of the cancer patient.

In Philadelphia it has become known that there is an influential group of the profession which is making every effort to see this thing through. It is their desire to reach every office and clinic in Philadelphia so that as the doctor examines his patient he will sense the presence of a sympathetic but critically observing influence in the essence of the Committee which will influence him to discharge his full duty to the cancer patient. There are indications that this influence has begun. Physicians have sought the advice of the Committee as to the proper approach to specific problems with their patients. This was done not only to affect the correct diagnosis but to insure the physician that if the case did appear before the Committee he would be in the clear. In other instances physicians have explained the detailed reasons for a delayed diagnosis before the case actually came to the attention of the Committee's investigators.

The success of this educational program still has to be proved. However, these few examples of influence exhibited in various ways do seem to indicate the Committee is accomplishing something worth while. No doubt the immeasurable influences must precede the measurable standards by which the attack on the delay period can be statistically recorded.

Finally, the Committee has compiled as a result of its findings certain minimum standards for the handling of the female patient from the standpoint of the early diagnosis of pelvic cancer. The ten points so presented incorpate the commonest causes of delay with appropriate constructive remedial suggestions for eliminating these factors. The outline is presented under the title of "A Decalogue for the Early Diagnosis of Pelvic Cancer." This Decalogue was presented before a recent state medical society meeting and has as yet not been published.[5] At this time I would like to read the ten items of the decalogue as further evidence of positive results of the Committee's activity.

1. History and Pelvic Examination.—On the first visit take a careful history, noting variations in menstruation, leukorrheal discharge, intermenstrual or postcoital bleeding, bloody discharge, abdominal pain, or irritation of the vulva. Perform a pelvic examination, including the use of a speculum. Use a good light and examine the patient even if she is bleeding.

2. Biopsy of the Cervix.—Obtain an adequate biopsy specimen in all lesions of the cervix that bleed or of simple erosions that do not heal following cauterization. Perform the biopsy by scalpel and include the important squamocolumnar junction of the portio and endocervix.

3. The Cervical Polyp.—Always precede a cervical polypectomy, including the base, by a dilatation and curettage and biopsy of the cervix.

4. Gross Pelvic Pathology.—Perform a pelvic examination on every patient who has unexplained abdominal symptoms, either with or without abnormal vaginal bleeding, to exclude ovarian cancer. Perform a dilatation and curettage and biopsy of the cervix in every case of abnormal vaginal bleeding or bloody discharge, even if associated with demonstrable pelvic pathology, such as ovarian cyst or uterine fibroid.

5. The Menopause.—Assume menopausal cycles to be normal only when the amount of bleeding and the frequency of occurrence of the periods decrease or remain constant. Any variation from this, or any postmenopausal bleeding, requires a diagnostic dilation and curettage and biopsy of the cervix.

6. Atrophic Lesions.—Perform a dilatation and curettage and biopsy of the cervix in every case of bleeding or staining associated with "senile vaginitis." Examine carefully all lesions of the vulva and biopsy prior to instituting treatment.

7. Hormonal Therapy.—Withhold all hormonal therapy for abnormal vaginal bleeding until a diagnostic dilatation and curettage and a biopsy of the cervix have been performed.

8. X-ray and Radium Therapy.—Never apply radium or roentgen therapy to the vulva, vagina, or other pelvic organs without prior examination, dilatation and curettage, and biopsy. Consider leukoplakia as a possible precursor of cancer requiring biopsy.

9. Periodic Examinations and Careful Follow-Up.—Advise all patients to have periodic pelvic examinations. Perform periodic pelvic and cytologic examinations (Papanicolaou smear) and, when indicated, repeat the dilatation and curettage and biopsy of the cervix in those cases in which the original diagnostic dilatation and curettage and cervical biopsy showed no histologic evidence of a malignancy but the abnormal symptoms have persisted or recurred.

10. Cancer Consciousness.—Keep the possibility of cancer always in mind when evaluating gynecologic symptoms.

Summary

1. The organization and method of procedure of the Committee for the Study of Pelvic Cancer is described.

2. A brief statistical review is presented to indicate the physician's relationship to the diagnostic delay period in pelvic cancer.

3. The possible influence of the Committee's activities on the individual physician and the hospitals of Philadelphia are suggested.

4. A brief reference is made to the decalogue for the early diagnosis of cancer in the female genital organs.

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2. Pack, G. T., and Gallo, J. S.: Culpability for delay in treatment of cancer, Am. J. Cancer 33:443–462 (July) 1938.
3. Leach, J. E., and Robbins, G. F.: Delay in diagnosis of cancer, J.A.M.A. 135:5–8 (Sept. 6) 1947.
4. Howson, J. Y., and Montgomery, T. L.: An attack upon the delay period in the diagnosis of pelvic cancer with further observation of the Philadelphia study, Am. J. Obst. & Gynec. 57:1098–1106 (June) 1949.
5. Howson, J. Y., and Golub, L. J.: A decalogue for the early diagnosis of pelvic cancer, to be published.

PUBLIC HEALTH WORKERS INVITED TO MEETING SPONSORED BY IOWA GROUP

A special invitation is being extended to all individuals interested in public health work to attend a Middle States meeting in Des Moines, Iowa, on May 4 and 5. Twelve states are being invited to attend this first meeting upon the invitation of the Iowa Public Health Association.

The program has been arranged by a committee from those states which met at the time of the American Public Health Association convention in New York. It is anticipated that from this first organizational meeting there will be formed a Middle States Health Branch of the American Public Health Association here in the Middle West.

The program for this first meeting is to be based upon the possibility of wide participation by all those who attend. Varied interests in the field of public health will be grouped together and several discussion meetings will be held for each group. This will permit wide participation and an opportunity for discussion regarding the problems of public health workers throughout the twelve states.

Specific information on the meeting may be obtained from Leonard C. Murray, Director of Public Health Education, Iowa State Department of Health, Des Moines 19, Iowa.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Atabrine and Parenteral Quinidine in Treatment Arrhythmias

Evidence has accumulated concerning the unusual parallelism of physiologic properties between atabrine and quinine in spite of their totally different chemical structures. Quinidine, an isomer of quinine, restores regular sinus rhythm in auricular fibrillation and other arrhythmias by the following likely mechanisms: (*a*) lengthening the refractory period of atrial muscle by direct action and decreasing vagal inhibitory action on the atrium, (*b*) decreasing the rate of conduction in atrial muscle, and (*c*) depressing arteriovenous conduction.

Having found atabrine similarly effective in animal experiments, earlier reported, Menard M. Gertler and Steven B. Yohalem[1] used the drug in a series of patients with arrhythmias, either primarily or after ineffective quinidine medication.

Considering all the cases, including 5 of thyrotoxicosis and 1 of pheochromocytoma, atabrine restored regular sinus rhythm in 15 of 32 patients. If the 6 just mentioned are excluded, as there may be some justification for doing, then the percentage of atabrine successes is increased from 47 to 60, which is probably about what quinidine would accomplish. Best responses occurred in arteriosclerotic heart disease, which is usually refractory to quinidine. Atabrine was also effective in reverting auricular fibrillation to regular sinus rhythm in eight of sixteen trials where quinidine had failed. It was unsuccessful in 8 cases in which quinidine was also unsuccessful. In arrhythmias other than auricular fibrillation, 2 of the 5 patients who did not react to quinidine responded favorably to atabrine. Of the 8 patients in whom atabrine failed to restore regular sinus rhythm from auricular fibrillation after quinidine had also failed, 6 did not respond subsequently to quinidine and digitailis and 1 died before other therapy could be attempted. Similarly, in the arrhythmias other than auricular fibrillation, no measures were effective in restoring regular sinus rhythm following failure with atabrine.

The drug was injected intramuscularly in 0.3 to 0.6 Gm. dosage in 10 cc. of 1 per cent procaine solution. If there had been no response to quinidine, six hours was allowed to elapse before atabrine was given. Most of the arrhythmias reverted to regular sinus rhythm is eighty minutes, and in all but 2 cases within two and one-half hours, of the injection.

This interesting report certainly makes it appear that extensive trial of atabrine in the arrhythmias is worth while. The drug appears to be most successfully employed when the disturbance of rhythm has not been of long duration, which is true also of quinidine.

In certain acute or paroxysmal arrhythmias, the abnormal rate and rhythm may cause cardiac pain, intense palpitation, dyspnea, vomiting, a shocklike state and even death. In these conditions where quinidine is of recognized efficacy it may be of advantage to give it parenterally for greater certainty of effect. Other indications for parenteral quinidine administration are vomiting and diarrhea, moderate or severe grades of congestive failure when absorption by mouth is slow and uncertain, and the presence of any condition which might prevent oral ingestion.

Samuel Bellet and John Urbach[2] have had little experience with quinidine hydrochloride or quinidine lactate given intravenously but have used quinidine gluconate intramuscularly satisfactorily in 15 patients, some of whom received as many as ten injections at varying intervals. The solution of this salt is stable, its injection does not result in irritation, and in giving it one does not introduce other compounds such as antipyrin incorporated in other preparations to maintain quinidine in solution.

Characteristic quinidine effects were obtained clinically within fifteen minutes following injection of 5 to 7½ grains: abolition of ventricular extrasystoles, slowing of auricular rate and auricular fibrillation, production of characteristic changes in the T waves and Q–T intervals in patients with normal sinus rhythm. The preparation is suggested for use in patients in whom a rapid effect is required or in whom the administration of quinidine orally is not considered feasible.—HARRY BECKMAN, M.D.

REFERENCES

1. Gertler, M. M., and Yohalem, S. B.: The effect of atabrine on cardiac arrhythmias, Am. Heart J. 37:79–91 (Jan.) 1949.
2. Bellet, S., and Urbach, J.: A new intramuscular preparation of quinidine (quinidine gluconate), J. Lab. & Clin. Med. 34:1118–1120 (Aug.) 1949.

. . . . THE PRESIDENT'S PAGE . . . .

No Whitewash Here

IF THERE is one thing that I should like to tell the reader of recent press and public criticism of the licensing procedures for foreign trained physicians it is this:

No one, least of all the public, should be blind to the dangers of indiscriminate licensing, *for it is the privilege of the people that they be assured of competent medical practitioners.* Members of the Council of the State Medical Society and the State Board of Medical Examiners, at least, are well aware of their serious responsibilities in this field of public health.

The action of the Council, after a thorough airing of the situation with the Board on February 18, was predicated on this basis alone. Its statement to the press is reprinted in full in the Medical Forum section of this issue of the *Journal.* Let me set forth here, for the record, the facts and accomplishments of that meeting, which although known to the press, were almost without exception not reported by it.

Let Only These Facts Stand In Judgment of the Council's Action

1. The meeting on February 18 was a meeting of the Council, with Board members as guests. Not all members of the Board were present.
2. The Wisconsin Board was the motivating force behind the AMA study of foreign schools, which to date has resulted in approval of 38 schools.
3. Members of the Board present said they would accept graduates of schools already approved by the AMA and those from schools approved in the future.
4. Members of the Board indicated that they will meet in April to prevent undue delay in handling applications now on file from graduates of approved schools.
5. Studies of foreign schools are continuing, with nearly 210 schools awaiting evaluation. Evaluation is a complex problem, and must be conducted on the spot. However, even the United States State Department has counselled the AMA to delay visits to some countries.
6. Members of the Board at the meeting indicated that they would accept applications from graduates of schools not as yet approved by the AMA. In such cases, the applicant has the burden of proof in demonstrating what the *law* requires him to show —that he was trained under the same general conditions as are required of those attending the medical school of the University of Wisconsin.
   It must be recognized, that, by obtaining this commitment from the members of the Board at the meeting, the Council gave no support to any kind of "closed shop" or blanket exclusion policy.
7. Before the next legislative session the State Medical Society will study means of creating an appropriate law to give the Board legal authority it does not now have of considering an applicant's additional training since graduation as raising his level of school training to equivalency with that provided in this country.
8. It will also study the possibility of a special "educational license" for foreign graduates who, in some cases, may find it impossible to obtain a regular license with which to complete their education.
9. Finally, the State Medical Society has placed its services and facilities at the disposal of the Board of Examiners to aid in any way possible the evaluation of schools and credentials.

These are not the actions of a Council bent on whitewashing or covering-up for the Board. Nor do they satisfy some who feel that head-chopping would have accomplished more than constructive thinking. They do, however, emphasize that some very significant progress was made at the meeting.

John Wm Truitt MD

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

E. H. JORRIS

Doctor Jorris, a 1939 graduate of the University of Minnesota Medical School, joined the Wisconsin State Department of Health in 1936 as a district health officer with headquarters at Sparta. Taking time out to gain an MSPH degree at Michigan in 1940, he returned to the department as supervisor of local health services and director of the tuberculosis division. He served in the Naval Reserve (MC) in World War II, attained the rank of commander, and returned to the department in 1946 as assistant state health officer.

Health is increasing in popularity as a subject for magazine articles. With the rapid advances being made in medicine, we often find ourselves reading a sensationalized story of some miracle drug even before we have had an opportunity to see the carefully weighed report of scientific study.

Mr. and Mrs. Jones, your patients, are pretty well read individuals. They may have some misconceptions regarding the usefulness or limitations of new medical discoveries but they do know something about them. Not all of the material they read is poor; many of the articles on health are well written and play an important part in shaping their health habits.

You as a physician are apt to be behind the proverbial eight-ball unless you not only read what they read, but keep one jump ahead of them by continuous study and postgraduate or refresher training.

The physician today who gives a careful physical examination and practices sound scientific medicine soon finds that his patients are well aware of this fact and that they make it a point to tell their friends. In small communities the word soon gets around which of the physicians is keeping up to date through postgraduate training.

The general practitioner, now more than ever before, finds it increasingly difficult to keep up with modern medical advances; yet he fully recognizes the necessity for doing so. In recognition of this need, the American Academy of General Practice was organized. It has the unusual requirement that the members take a specified number of hours of postgraduate training over a specified period of time in order to retain their membership.

The problem of providing postgraduate training, which will be available to all physicians in Wisconsin and which will not unduly interfere with the already crowded schedule of the physician, is not an easy one. It also must be recognized that there are as many varied opinions on what should be emphasized in postgraduate training as there are special groups interested in medical problems.

The Committee on Scientific Work of the State Medical Society, in recognition of the need for an expanded postgraduate training program and the problems involved in its organization, established a subcommittee known as the Coordinating Committee on Postgraduate Education. This Committee is made up of representatives of the University of Wisconsin, Marquette University, the State Medical Society, the State Board of Health, the American Academy of General Practice and the principal voluntary agencies interested in medical problems, including the Wisconsin Anti-tuberculosis Association, the Wisconsin Division of the American Cancer Society, the Wisconsin Chapter of the National Foundation for Infantile Paralysis, and the Wisconsin Heart Association. The committee was charged with the task of planning a balanced program of postgraduate education for Wisconsin physicians, which would be adequate to meet their needs, and coordinating all of the available resources in Wisconsin for the implementation of the program. The committee was asked to bear in mind the problem of the general practitioner in rural areas who is unable to leave his practice for extended periods of time and to plan for these physicians a program which would bring postgraduate education to them. The State Medical Society may well be commended for its efforts in the advancement of this plan.—E. H. Jorris, M. D., *Assistant State Health Officer.*

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL TO HOLD ALUMNI DAY

The University of Wisconsin Medical School will hold its annual Alumni Day on Thursday, May 18. All alumni are asked to mark this date on the calendar and plan to attend.

Proceedings of the Milwaukee Academy of Medicine February 21, 1950

Serum Protein Changes in the Diagnosis of Cancer*

By ELWOOD V. JENSEN, M. D.
Chicago

ONE of the favorite places to look for evidence of disease in the body has been the blood stream. This is a most convenient place, and since this fluid penetrates practically all of the tissues of an organism it may be modified by abnormal processes. It is the detection of such changes in cancer in which we are interested at the moment.

We are chiefly concerned with the blood proteins which are classified into six types: namely, hemoglobin, fibrinogen, albumin, alpha globulin, beta globulin, and gamma globulin. The total of all of these in the normal body state is in the neighborhood of 7.3 Gm. per hundred cubic centimeters. Each of these is not a distinct chemical compound, and subtypes have been determined, especially in the globulin fractions.

Each of these protein substances has a particular function. According to present thinking these are given as follows: albumin regulates osmotic pressure (thereby controls fluid balance between the blood and the tissues) and enters reversible combinations with a great many ionic substances as well as with vitamin K; alpha and beta globulins are closely tied up with certain lipids, carbohydrates, and steroids, probably functioning to bring into solution in the blood these very difficult soluble substances; gamma globulins are concerned with antibody formation and combination.

Determinations for measuring the amounts of these various protein fractions are numerous and for the most part inaccurate, whilst the accurate ones are most difficult to perform. It should be pointed out that the common "salting out" procedures of separating albumin from the globulins (such as Howe method) usually separate alpha globulin with the albumin, and the proportion of the alpha globulin may be high in certain pathologic states. Other procedures, such as electrophoresis, ultracentrifugation, and immunologic assay are research methods not yet practical for the routine laboratory.

In general, one can say that in diseases wherein albumin is decreased often there is an increase in one or more of the globulin fractions. Therefore the *total* protein may be decreased, increased, or remain essentially normal, depending on whether or not the increase in the globulins is enough to compensate for the decrease in albumin. *Albumin* is decreased in liver disease, nutritional disturbances, nephrosis, early tuberculosis, sarcoid, rheumatoid arthritis, cancer, and lymphogranuloma. *Alpha globulin* is increased in wasting diseases, in conditions of tissue destruction, nephrosis, late tuberculosis, rheumatoid arthritis, and cancer. *Beta globulin* is increased in nephrosis, cirrhosis, hepatitis, and multiple myeloma. *Gamma globulin* is increased in hepatitis, lymphogranuloma, tuberculosis, sarcoid, rheumatoid arthritis, multiple myeloma, lobar pneumonia, and in the cases of increased titer of various antibodies.

Whole blood plasma and serum have been intensively investigated during the past decade or two, in the hope that some abnormality peculiar to neoplasia would be discovered. No such abnormality has yet been found; in other words, there is *no specific* blood test for cancer. It is true that cancer serum does differ from normal serum in many respects, but for every property in which cancer serum is unusual there are other noncancerous conditions which produce similar changes. I feel, further, that practically all of the tests which have been proposed for the detection of cancer are markedly influenced by variations in the relative amounts of the normal plasma or serum proteins, especially since most of the comparisons have been made on the basis of equal volumes serum rather than on the basis of the protein that is actually there. This may be the explanation why practically all of the tests show false positive reactions with certain nonmalignant diseases.

The differences in cancer serum which have been observed belong in three general categories: the level of enzymes which are present, the abnormal amounts of certain enzyme-inhibiting substances, and peculiar properties of the protein fractions. The latter category is our chief interest.

In our laboratory we have studied the thermocoagulation of the serum, and it appears to us that the proteins of cancer serum differ from the proteins of normal serum. It seems that cancer sera have a decreased ability to form a solid clot when heated. This difference can be observed in two ways: inhibitor method and dilution method. As *inhibitor*, we use sodium iodoacetate, which is added in variable amounts to a constant amount of serum. The largest amount of iodoacetate that permits clot formation upon heating of the serum is taken as the end-point and this is then converted to an "index", which is the unit amount of iodoacetate that we need for a unit weight of serum. Normal

* The complete paper by Doctor Jensen is available from the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3.

sera give an index above 9, while that below 9 is classified as abnormal. The *dilution* method is the simplest and most reproducible. A series of Wassermann tubes is set up with a range in serum content beginning with 0.15 ml., 0.16 ml., etc., with enough buffer (Sorenson's) to bring the volume of each tube to 1.0 ml. These tubes are heated in boiling water for thirty minutes, cooled, and examined for clots by pouring on an eight mesh screen. The endpoint is taken as the lowest serum concentration that will form a solid clot. The actual serum protein concentration in this tube is calculated from the figure of dilution and the figure of total serum protein content of that patient's serum sample. Normal serum protein has been found to clot at 1.38 Gm. per hundred cubic centimeters of protein, while cancer serum being deficient in coagulation property is needed in greater amounts (greater protein concentration) to form a clot. A value of 1.40 Gm. per hundred cubic centimeters is taken as the dividing line between normal and abnormal sera.

By these methods we have invariably found that serum from healthy individuals gives a normal reaction. Cancer sera are abnormal—87 per cent by the iodoacetate inhibition test, and 85 per cent by the least concentration coagulation test. In non-malignant diseases the majority of patients show a normal reaction; however, tuberculosis and pregnancy invariably show an abnormal result. Other diseases, such as cirrhosis of the liver, hepatitis, ulcerative colitis, uremia, and rheumatoid arthritis may give an abnormal result. The basis of the reaction in our test appears to be a decrease in albumin content possibly also associated with changes in type or in combinations which the albumin may have with other substances. It is peculiar that the injection of ACTH and surgical procedures will give a "cancer reaction."

In summary, it is possible to say that finding such abnormalities in the serum proteins (positive Huggins test) is an indication of some serious disease. If one excludes other causes for an abnormal reaction, such as tuberculosis, pregnancy, and surgery, then the test indicates very strongly the possibility of the presence of cancer. The test is also used in measuring the activity of the cancerous disease, especially after treatment. It, therefore, may be used as objective criteria in prognosis, since we have observed a return to normal after successful extirpation of a cancer. This is not a specific test for cancer, but with proper interpretation it can be a useful tool in the diagnosis of cancer.

Introducing the Guest Editorialist

The man interested in a career in military medicine could find no better counselor than Rear Admiral Clifford A. Swanson, M. C., Surgeon General of the United States Navy, one of the youngest medical officers ever appointed to this high office.

The twenty-fourth chief of the Navy Bureau of Medicine and Surgery hails from Michigan and is the fourth Surgeon General to have been selected from states west of the Allegheny Mountains. His distinguished scholastic career was climaxed by a cum laude degree of Doctor of Medicine from the University of Michigan Medical School in 1925. Just out of school he was appointed assistant surgeon in the United States Navy with the rank of lieutenant, junior grade.

His first sea duty was on the U. S. S. Dobbin. He sailed around the world in 1935, just "414 years after Magellan," as Admiral Swanson likes to express it himself. This trip expanded his interest in diseases of the eye, and after three years' service in the Philippine Islands, he did postgraduate work in eye, ear, nose, and throat at Harvard and the University of Pennsylvania.

World War II found him performing valuable research on night and color vision and the effect of pressure and oxygen consumption on the eye that was of great significance in both aviation and submarine medicine. He was an advisor on the designing and equipping of eye, ear, nose and throat departments aboard hospital ships. Later he went to sea as senior medical officer on the battleship Iowa and then served on the staff of the Commander, Battleships, Atlantic Fleet.

He was the medical officer designated to accompany the Congressional Committee inspecting Hiroshima and Nagasaki and one of the surgeons that accompanied the Roosevelt party to Teheran. He represented the United States at the Pan-American Eye Congress at Montevideo.

Admiral Swanson has written a number of professional articles dealing with his specialty for the U. S. Naval Medical Bulletin, the Journal of the American Medical Association, and the American Journal of Ophthalmology.

A Career in Military Medicine

NOWHERE in the United States can a recent graduate in medicine or dentistry obtain training in certain fields in these professions that excels that offered by the Medical Departments of the Armed Forces.

Since the earliest days of this nation the professional competence of the naval medical officer—and of the medical and dental officers of the Armed Forces—has been predicated upon postgraduate training and research. Further, to enable him to carry out his mission during peace or war, his armamentarium has always been the finest. In fact, the medical equipment of the various field medical facilities, be they those of a sick bay of a field dispensary, or the sick bay of a transport, a cruiser or aircraft carrier, or the portable medical equipment of the medical detachment of a landing force, has been equal to that of the very best equipped hospital, and that of the hospital has been the finest available.

Postgraduate training and research have always been a vital component of the medical services. In 1902 the United States Naval Medical School was established because nowhere else in this country was it possible to obtain the special training demanded by the naval medical service. For many years this medical school was the principal center in the United States for teaching tropical medicine. This school served as a field of operation from which were made many contributions to the fields of bacteriology, tropical medicine, and preventive medicine. Today, the Naval Medical Research Center and the United States Naval Dental School have succeeded the Naval Medical School; in addition, other naval medical research units have been established in various sections of this country as well as abroad: in Cairo, in Guam, and in Samoa. The fields of research in which these units have been engaged have been as varied as the fields of medicine and surgery, and have included the problems of the control of tropical diseases; the control of dysentery, diarrhea, and water-borne diseases; the control of rheumatic fever and streptococcal diseases; the effects of atomic energy on men and material; the effects of disorientation during flight; and the numerous and ever expanding phases of clinical medicine and surgery as well as the field of preventive medicine, preventive surgery, and preventive psychiatry. Indeed he must also be fully informed regarding the practical application of the many technologic advances to military medicine; the surgical aspects of the special weapons of amphibious warfare; of the practical application of the study of physical tolerance of personnel to design, construction, and performance of the modern submarine and the jet-propelled airplane.

These are but a few of the subjects that require the attention of the naval medical officer, and such is our concept of the necessity for postgraduate study and training. We consider that the naval medical officer must exemplify the finest type of physician, be aware of the newest in the science and art of medicine and surgery, and be guided by Hippocratic medicine. At the same time, he must fully realize his responsibilities not only for the physical and psychologic welfare of the military personnel, but also of all mankind.

C. A. Swanson

Rear Admiral (MC)
Surgeon General, U. S. Navy

OFFICIAL CALL FOR

Scientific Exhibits

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1950 ANNUAL MEETING **MILWAUKEE** **OCTOBER 2–3–4**

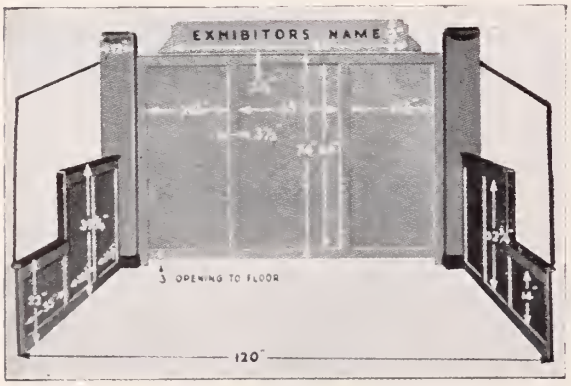
★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1950 Annual Meeting. The exhibits will be located in the main arena of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1950 meeting are requested to file an application BEFORE MAY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Wooden booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, and special lighting equipment required for this display.



In connection with the display of exhibits furnished by individuals outside of Wisconsin, the same rules as noted above will apply, but, in addition, the State Medical Society will provide hotel accommodations and reimburse the exhibit attendant for his travel, meals, and incidental expenses.

Booths for scientific exhibits are constructed of light green wood, in the dimensions shown on the chart at the left, *with this exception:* The side panels used for the exhibits of the State Medical Society are 6′ 5″ high and 9′ long.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by May 1. No applications can be accepted after that date. Address your communications to T. O. Nuzum, M.D., director of scientific exhibits, % The State Medical Society of Wisconsin, 704 East Gorham Street, Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1950 ANNUAL MEETING MILWAUKEE OCTOBER 2-3-4

Fill Out and Mail to:

T. O. NUZUM, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
704 East Gorham Street
Box 1109
Madison 1, Wisconsin

1. Title of exhibit: _____

2. Description of exhibit (attach 200 word description to this blank): _____

3. The standard booth is 10′ x 10′. _____

   How many booths will your display require? _____

4. Will radiologic viewing boxes be needed? If so, will you furnish them? _____

   (The State Medical Society does not have equipment of this character available, but it can be rented by the exhibitor through the Advertising Display and Decorations Company of Cleveland, Ohio)

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

BOARD OF OBSTETRICS AND GYNECOLOGY SCHEDULES EXAMINATIONS

The general oral and pathology examinations (Part II) for all candidates will be conducted at The Shelburne, Atlantic City, N. J., by the entire board from May 21–28. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates.

Candidates for re-examination in Part II must make written application to the Secretary's office not later than April 1.

Applications are now being received for the the 1951 examinations. Application forms and Bulletins are sent upon request made to Paul Titus, M. D., Secretary, American Board of Obstetrics and Gynecology, Inc., 1015 Highland Building, Pittsburgh 6, Pennsylvania.

Society Proceedings

Ashland—Bayfield—Iron

"Surgical Management of Carcinoma of the Colon" was the subject presented before a meeting of the Ashland–Bayfield–Iron County Medical Society at the Menard Hotel in Ashland on January 31. *Dr. F. D. Weeks* of Ashland discussed the topic, and *Drs. W. J. Tucker* and F. F. Golden led the discussion. At the business session *Dr. C. A. Grand* was named to head the organization for the coming year. Officers who will serve with him include *Drs. J. M. Jauquet*, vice-president; *J. E. Kreher*, secretary; *J. W. Prentice*, delegate; and *J. E. Kreher*, alternate delegate. It was voted to endorse the program of the Wisconsin Heart Association, and, following a discussion of the meeting of the House of Delegates of the State Medical Society by Doctor Prentice, Ashland, delegate, the action to be taken in that area for public relations work and information purposes was discussed. A public relations committee was appointed, to consist of Doctors Prentice, Jauquet, and Kreher.

Brown—Kewaunee—Door

A film, "Gelfoam in Surgery," was made available by the Upjohn Company for a meeting of the Brown–Kewaunee–Door County Medical Society at the Beaumont Hotel in Green Bay on February 9. The film was recently produced by workers at the University of Minnesota and Mayo Clinic. Through the courtesy of Mr. E. R. Wolfe of the Upjohn Company, a social hour preceded the dinner meeting.

Clark

Members of the Clark County Medical Society held a dinner meeting at Keller's Silver Dome Supper Club at Neillsville on December 8, when they heard a talk on "Common Afflictions of the Knee and Shoulder in General Practice" by *Dr. Charles Ihle* of Eau Claire. At a brief business meeting which followed, a resolution was unanimously adopted opposing any form of compulsory sickness insurance. The secretary was instructed to send copies of the resolution to the United States senators and congressmen from that area.

Douglas

A "Survey of Cesarean Section from the Years 1939–1949 Inclusive" was given to members of the Douglas County Medical Society when they met at the Hotel Superior in Superior on January 4. *Dr. James W. McGill* presented the survey, which was discussed by *Drs. H. A. Sincock, V. E. Ekblad, Robert Jackson, Richard Fruehauf, Fred Johnson, Roger Thompson*, and *L. W. Beebe*, all of Superior.

Eau Claire—Dunn—Pepin

Meeting at the Hotel Eau Claire in Eau Claire on February 27, members of the Eau Claire–Dunn–Pepin County Medical Society heard a talk by Dr. William C. Tucker of Minneapolis. Doctor Tucker, who is associate professor of medicine at the University of Minnesota Medical School, discussed "Ideopathic Pleural Effusion."

Fond du Lac

A. R CURRERI

Guest speaker at the January 26 meeting of the Fond du Lac County Medical Society, held at the Hotel Retlaw in Fond du Lac, was *Dr. A. R. Curreri*, Madison, associate professor of surgery at the University of Wisconsin Medical School. Doctor Curreri presented a paper entitled "Tools Available to the General Practitioner in the Diagnosis of Mediastinal Diseases."

Jefferson

L. J. VAN HECKE

A Milwaukee pathologist, *Dr. L. J. Van Hecke*, spoke before a meeting of the Jefferson County Medical Society at the Blackhawk Hotel in Fort Atkinson on February 16. His subject was "Smear Technics in Cancer Diagnosis."

On January 19, the Society met at the Carlton Hotel in Watertown to hear a talk by Mr. Kenneth Kringle, director of the Jefferson County Welfare Department. Mr. Kringle discussed public relief as it applies to the physician.

Kenosha

"The Silent Gallstone and Gallstone Disease" was the subject for discussion at a meeting of the Kenosha County Medical Society held at the Elks Club in Kenosha on February 2. Dr. M. E. Lichtenstein of Chicago was the guest speaker of the even-

ing. At the business session, members voted to endorse a nationwide essay contest for junior and senior high school students on "Why the Private Practice of Medicine Furnishes This Country the Best Medical Care." The organization also endorsed the mobile tuberculosis unit for work in the county under the direction of the State Board of Health.

Manitowoc

H. L. CORRELL

The first step in the launching of the drive of the Wisconsin Heart Association in Manitowoc took place at the Hotel Manitowoc on January 26, when *Dr. Howard L. Correll*, Milwaukee, spoke before a meeting of the Manitowoc County Medical Society. Sponsored by the Wisconsin and American Heart Associations, Doctor Correll discussed "The Diagnosis and Treatment of Heart Disease and Interpretation of Electrocardiograms." Doctor Correll is an assistant clinical professor of medicine at Marquette University School of Medicine.

Oconto—Shawano—Marinette

Medical and surgical treatment of hypertension was discussed by two Milwaukee physicians at a joint medical meeting of the Oconto, Shawano, and Marinette County Medical Societies at a meeting in Stiles on January 11. The Menominee (Mich.) County Medical Society also attended the meeting. *Dr. Francis F. Rosenbaum*, vice-president of the Wisconsin Heart Association, discussed medical management of hypertension, and *Dr. James Conley*, clinical instructor in surgery at Marquette University School of Medicine, described surgical treatment of hypertension. *Dr. W. R. Berg*, Gillett, president of the Oconto County Medical Society, introduced the speakers, and after their talks, led a round table discussion on the subject.

Outagamie

The director of the State Laboratory of Hygiene in Madison and a past president of the State Medical Society, *Dr. W. D. Stovall*, was the guest speaker at a meeting of the Outagamie County Medical Society on January 19. The group met at the Elks Club in Appleton. Doctor Stovall spoke on "Uterine Carcinoma as Related to Papaniocolaou Stain."

"Ectopic Pregnancy" was the subject presented to the group on February 16 by Dr. William Geittmann, Chicago. Doctor Geittmann is obstetrician at St. Luke's and Cook County Hospitals in Chicago.

Pierce—St. Croix

Meeting in the church parlors of the Episcopal Church in River Falls on January 17, members of the Pierce–St. Croix County Medical Society were entertained by the River Falls Clinic group and *Dr. C. C. Peterson*, River Falls. Guest speaker for the session was Dr. A. J. Leemhuis of Minneapolis, who spoke on "Localization of Brain Lesions." Doctor Leemhuis has a practice in Minneapolis and is consulting neurologist for the Veterans Hospital at Fort Snelling.

Rusk

Dr. L. M. Lundmark of Ladysmith has been reelected president of the Rusk County Medical Society to serve for the coming year. Other officers include *Drs. M. L. Whalen*, Bruce, secretary; and *Woodruff Smith*, Ladysmith, alternate delegate. Doctor Lundmark will also serve as delegate to the State Medical Society.

Sheboygan

Dr. Homer H. Kohler, Sheboygan, was named president of the Sheboygan County Medical Society on January 12, when the group met at the Memorial Hospital in Sheboygan. He succeeds *Dr. Horace Hansen* of Sheboygan Falls. Other officers include *Dr. Steven O'Donnell*, Sheboygan, vice president; *Dr. James F. Hildebrand*, also of Sheboygan, secretary–treasurer; *Dr. John Martineau*, Elkhart Lake, censor; *Dr. Paul B. Mason*, Sheboygan, delegate; and *Dr. Joseph Russell*, Random Lake, alternate delegate.

Trempealeau—Jackson—Buffalo

J. C. FOX

"Cardiovascular Emergencies" was the topic discussed at the January 19 meeting of the Trempealeau–Jackson–Buffalo County Medical Society, held at the City Hall in Galesville. Guest speaker for the session was *Dr. James C. Fox* of La Crosse, Councilor from the Seventh District. *Dr. C. M. Kelly, Jr.* also of La Crosse, discussed the presentation.

Walworth

Dr. Maurice Hardgrove, president-elect of the Medical Society of Milwaukee County, was the guest of the Walworth County Medical Society on January 12, when the Society met at the Sterlingworth Hotel in Elkhorn. Doctor Hardgrove spoke on "Certain Aspects of the Relationship of ACTH to Disease and Health". A special tribute was given in memory of *Dr. Richard Halsey*, recently deceased

member of the organization. At the business session the arrangements being made for postgraduate clinical meetings at the Veterans Administration Hospital, Wood, were discussed.

Washington—Ozaukee

H. W. POHLE

Meeting at St. Joseph's Hospital in West Bend, members of the Washington – Ozaukee County Medical Society heard a talk by *Dr. Herbert W. Pohle*, of Milwaukee on January 26. The doctor, who is a clinical instructor in medicine at Marquette University School of Medicine, discussed "Hyperthyroidism."

Waukesha

Members of the Waukesha County Medical Society gathered at the Haselow Restaurant in Hartland on February 1 to hear a talk by *Dr. Lamont Schweiger* of Milwaukee. The doctor spoke on "Recognition and Treatment of Coronary Disease." At the business meeting, which preceded a dinner, the following committee appointments were made: Coordinating Committee on Medical Care Plans, *Dr. Paul Campbell*, Waukesha, chairman; and *Drs. L. C. J. Olsen*, Delafield, and *Donald Wilkinson*, Oconomowoc; Committee on Public Policy and Public Relations: *Dr. P. B. Theobald*, Oconomowoc, chairman; and *Drs. E. C. Van Valin*, Sussex, and *N. C. Schlossmann*, Waukesha; and Committee on Military and Disaster Medical Services: *Dr. F. L. Grover*, Hartland, Chairman; and *Drs. W. D. James*, Oconomowoc, and *Paul Campbell*, Waukesha. *Dr. H. F. Sydow*, Waukesha, was named liaison officer for school health projects.

Winnebago

A member of the department of internal medicine at the University of Wisconsin Medical School, *Dr. A. B. Weinstein*, was the guest speaker at a meeting of the Winnebago County Medical Society at the Hotel Menasha in Menasha on February 2. His topic was "The Care of Diabetic Emergencies."

Wood

Election of officers at the January 19 meeting of the Wood County Medical Society, held at Slim's Steak House at Marshfield, resulted in the following doctors being named to positions: *Drs. O. A. Backus*, Nekoosa, president; *R. S. Baldwin*, Marshfield, vice-president; *R. W. Mason*, Marshfield, secretary; *R. E. Garrison*, Wisconsin Rapids, delegate; and *F. X. Pomainville*, Wisconsin Rapids, alternate delegate. Three scientific papers were presented by Marshfield doctors; *Dr. F. J. Gouze* discussing "Clinical Observations with Clopane Hydrochloride"; *Dr. W. B. O'Connor* speaking on "Newer Drugs in Dermatology"; and *Dr. C. A. Vedder* discussing "Early Diagnosis of Breast Cancer." The Society went on record as (1) disapproving compulsory sickness insurance, (2) approving local, community, and county health councils, and (3) approving a Woman's Auxiliary.

Wisconsin Rheumatism Association

Meeting at the Veterans Hospital at Wood on January 25, members of the Wisconsin Rheumatism Association named *Dr. J. F. Wyman*, Milwaukee, president of the organization for the coming year. Doctor Wyman is a member of the staff of Sacred Heart Sanitarium in Milwaukee. Other officers who will serve include *Drs. A. W. Bryan*, Madison, vice-president; and *C. C. Edmondson*, Waukesha, secretary-treasurer. Drs. M. W. Garry, *Paul Collopy*, *Millard Tufts*, *W. J. Egan*, *M. C. Borman*, and *Ray Piaskoski*, all of Milwaukee, were named to the board of directors. *Dr. M. G. Peterman*, Milwaukee pediatrician, was the principal speaker at the session. Pointing out that the Wisconsin climate is not good for rheumatoid arthritis or rheumatic fever, he recommended that child patients with these diseases be moved, if possible to the warm, dry areas of southwestern United States.

SECOND CANCER FILM AVAILABLE

The Wisconsin Division of the American Cancer Society, 119 East Washington Avenue, Madison, and the Cancer Division of the State Board of Health, State Office Building, Madison, announce the availability of the second color, sound film prepared by the American Cancer Society for professional audiences. This second film is entitled "Breast Cancer, The Problem of Early Diagnosis." It is presented in 16 mm. sound, with running time as 34 minutes.

This film is especially well suited for use by county medical societies and hospital staff conferences. It is the second in the series, the first being "Cancer, The Problem of Early Diagnosis." While the second film has been planned as the sequel to the first film issued, it can be viewed independently.

County societies and hospital staffs are urged to make use of these excellent teaching films, and if possible to incorporate them in an evening program with a speaker on the subject of cancer.

INDUSTRIAL HEALTH CLINICS

■ D. E. DORCHESTER, M. D.
Chairman, Committee on Industrial Health

3 PLANT CLINICS

■ CONSOLIDATED WATER POWER & PAPER, WIS. RAPIDS

■ KOHLER MANUFACTURING CO., KOHLER

■ GLOBE-UNION, MILWAUKEE

The Committee on Industrial Health, in cooperation with the Industrial Hygiene Unit of the State Board of Health and the Milwaukee, Sheboygan, and Wood County Medical Societies, is sponsoring three important medical meetings as described below. These meetings are open to members of the State Medical Society of Wisconsin, the industrial nurses of Wisconsin, and to special guests of industry.

Reservations must be made in advance! The only cost is that of dinner. All other expenses, including reimbursement of speakers, is provided by the State Society and the State Board of Health.

Your participation in these meetings is urged.

— April 13 —

KOHLER MFG. CO. PLANT **KOHLER**

1:45 p. m.: Registration—Recreation Hall in Kohler Village (Recreation hall located at the corner of High Street and Highway 23. A sign will direct you to the exact location)

2:00 p. m.: Briefing of tour by Dr. H. N. Heinz and Mr. L. C. Conger, assistant secretary of the Kohler Company

2:15–3:30 p. m.: Plant Tour. The tour will cover the foundry, both new and old, the enameling processes, and other portions of the plant which have not been viewed by previous tours of physicians.

SCIENTIFIC PROGRAM

(In the Ratzkeller of the Recreation Hall)

4:00 p.m.: "The Treatment of Electric Burns": Ernest Miller, M. D., Milwaukee

4:30 p.m.: "The Treatment of Hand Injuries": William Frackelton, M. D., Milwaukee

5:00 p.m.: "Industrial Dermatosis": Clifford Kalb, M. D., Milwaukee

DINNER—6:30 P. M. WISCONSIN ROOM OF THE AMERICAN CLUB

SPEAKERS: A Representative of the Kohler Co.

"Industrial Safety": A. J. Matthias, Circuit Instructor in the Field of Supervisory Training, Wisconsin Schools of Vocational and Adult Education

"Managing the Cardiac in Industry": Chester Kurtz, M. D., Madison

(Use reservation blank on page 236)

April 20

CONSOLIDATED WATER POWER AND PAPER CO. WISCONSIN RAPIDS

1:45 p. m.: Registration at the Main Plant (watch for signs)
2:00 p. m.: Briefing of tour by Mr. George Nelson, director of safety, Wisconsin Water Power and Paper Co.

2:15–3:30 p. m.: Plant Tour. The plant tour will cover all of the industrial processes in the production of coated stock paper, and a brief tour of the power plant. The tour will be planned to highlight sources of injury and exposures as revealed by accident records of the plant.

AFTERNOON SCIENTIFIC PROGRAM
(In Conference Room of Main Plant)

4:00 p.m.: "The Treatment of Electric Burns": Ernest Miller, M. D., Milwaukee

4:30 p.m.: "The Treatment of Hand Injuries": William Frackelton, M. D., Milwaukee

5:00 p.m.: "Industrial Dermatosis": Clifford Kalb, M. D., Milwaukee

DINNER—6:30 P. M. ELKS CLUB

SPEAKERS:

"Industrial Safety": A. J. Matthias, Circuit Instructor in the Field of Supervisory Training, Wisconsin Schools of Vocational and Adult Education

"The Management of the Cardiac in Industry": Chester Kurtz, M. D., Madison

(Use reservation blank on page 236)

May 3

GLOBE-UNION (900 E. KEEFE AVE.) MILWAUKEE

1:15 p. m.: Registration (in cafeteria facing East Keefe Avenue)
Note: **If your name begins with the letters A–M inclusive, please report for registration and briefing *before 1:30*. If your name begins with the letters N–Z please report for registration and briefing at 1:45.**

2:00–3:30 p. m.: Plant Tour. The plant tour will cover a variety of exposures and illustrate in particular the controls used to protect the workers from such hazards as lead poisoning. Be sure that you take the plant tour, as it will be directly related to the scientific program.

SCIENTIFIC PROGRAM
(Sky Room—Hotel Plankinton)

Chairman: D. E. Dorchester, M. D., Chairman, Committee on Industrial Health, State Medical Society

4:00 p.m.: "The Treatment of Hand Injuries": Harvey S. Allen, M. D., Associate in Surgery, Northwestern University Medical School, Evanston, Ill.

4:30 p.m.: Discussion and questions

4:45 p.m.: "Toxic Solvents": Elston Belknap, M. D., Milwaukee

5:15 p.m.: Discussion and questions

DINNER—6:15 P. M. SKY ROOM, HOTEL PLANKINTON

Ernest Miller, M. D., Milwaukee, Toastmaster

DINNER SPEAKERS: "Industry Looks at the Doctor": B. A. Krawczyk, Director of Compensation Dept., Allis Chalmers Mfg. Co., Milwaukee

"Industrial Aspects of Heart Disease": LeRoy H. Sloan, M. D., Professor of Medicine, University of Illinois Medical School, Chicago

(REGISTRATION AND DINNER: $3.50)

(Use reservation blank on page 236)

News Items and Personals

Dr. Karl H. Doege Retires as Editor of Journal

K. H. DOEGE

R. S. BALDWIN

After serving for more than ten years as medical editor of the Wisconsin Medical Journal, *Dr. Karl H. Doege*, Marshfield, recently retired from that position, effective with the March issue. *Dr. R. S. Baldwin*, also of Marshfield, has been appointed his successor for a two year term.

Doctor Doege, who is a member of the staff of the Marshfield Clinic, served as president of the State Medical Society last year. A diplomate of the American Board of Internal Medicine, he has been a member of the Council on Scientific Work since 1941.

Doctor Baldwin is also on the staff of the Marshfield Clinic, in the department of internal medicine. He served as a lieutenant colonel in the Army Medical Corps for five years, rejoining the clinic staff in 1945.

Dr. Chalmer Davee Elected to Head Hospital Staff

Meeting at the River Falls City Hospital on February 14, members of the hospital staff named *Dr. Chalmer Davee* chief of staff to succeed *Dr. C. A. Dawson*, who had held the position since the organization of the staff in 1939. *Dr. C. E. McJilton* will continue his duties as secretary.

Dr. C. H. Boren Addresses Marinette Kiwanians

Dr. C. H. Boren, Marinette, spoke before a meeting of the Kiwanis Club of that city on January 9, discussing the "Presence of Heart Disease in Business Men." Doctor Boren is a member of the staffs of the Boren Clinic and Marinette General Hospital.

Dr. C. J. Smiles Heads Ashland Hospital Staff

At a meeting of the staff of Trinity Hospital Ashland, on January 18, *Dr. C. J. Smiles* was elected chief of staff for the ensuing year. *Dr. W. E. Bargholtz* will serve as secretary. At the meeting, Dr. F. F. Golden joined the staff as radiologist; he has been in charge of the x-ray department since early in November. The addition of Doctor Golden to the staff was made possible by a grant from the Kellogg Foundation of Battle Creek, Mich., which is also providing new equipment to replace the present equipment of the department.

Brothers Celebrate Birthday of Dr. William Hipke

Gathering in Marshfield on January 12, three brothers of *Dr. William Hipke* helped him celebrate his eighty-fifth birthday. They are *Dr. G. A. Hipke* of Milwaukee, Arthur S. Hipke of Chilton, and Alfred T. Hipke of New Holstein.

Doctor Hipke, who is the oldest of the brothers, is one of the founders of the Marshfield Clinic. A graduate of the University of Illinois College of Medicine, he studied at Vienna, Austria, on two different occasions. He began practice in Marshfield in 1909, specializing in ophthalmology and otolaryngology. In 1916 he and five other physicians founded the Marshfield Clinic. He retired ten years ago. Both he and Dr. G. A. Hipke are members of the Fifty Year Club of the State Medical Society.

Hospital Staff at Rice Lake Elects Officers

Dr. N. A. Eidsmoe of Rice Lake was named chief of staff of the Lakeside Methodist Hospital at a meeting of the staff on January 24. He succeeds *Dr. J. F. Maser*, also of Rice Lake. Officers who will serve with Doctor Eidsmoe include *Dr. J. B. Balken*, Chetek, vice-president; and *Dr. C. H. Mahaffey*, Barron, secretary.

Reedsville Physician Attends Centennial Observance

Dr. E. C. Cary, Reedsville, attended the sixth annual clinical conference of the Chicago Medical Society, held at the Palmer House, Chicago, February 28 to March 3. The conference marked the one hundredth anniversary of the Chicago Medical Society and consisted of scientific discussion, color television of surgical procedures, and scientific and technical exhibits.

On his return home, the doctor attended the clinics of the Wisconsin Academy of General Practice, held at Marquette University School of Medicine, Milwaukee, on March 4.

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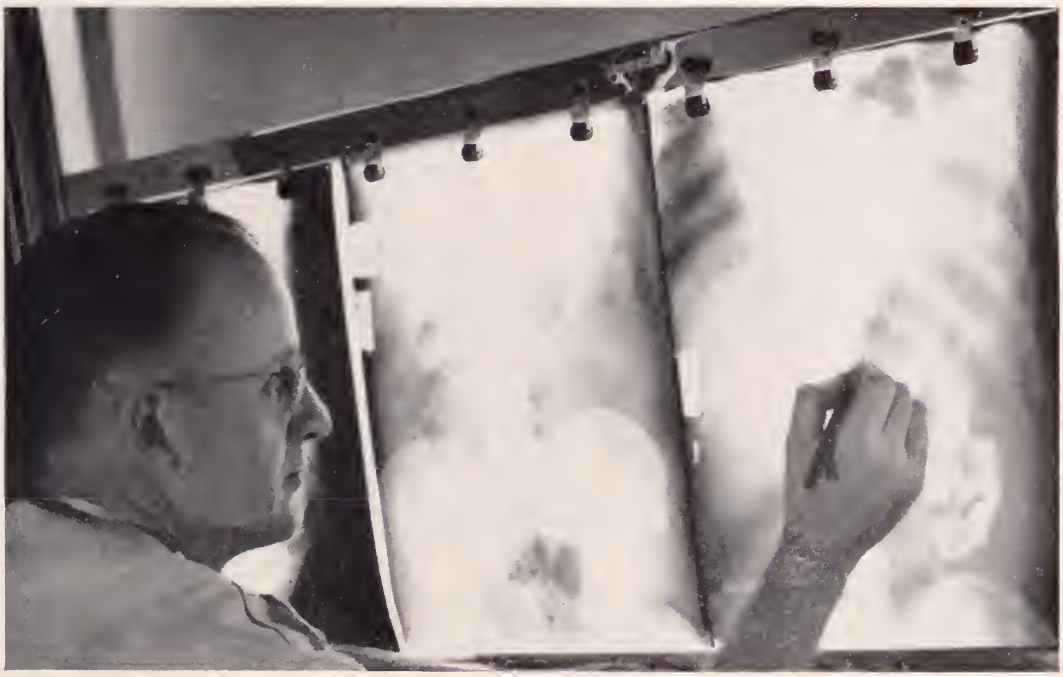

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Eau Claire Physician Named to Nursing School Council

At a regular meeting of the Luther Hospital School of Nursing Council on January 30, *Dr. J. H. Wishart*, Eau Claire, was named to the Council to succeed *Dr. S. L. Henke*, also of Eau Claire. Doctor Henke has represented the medical staff on the Council for many years. Doctor Wishart is a member of the department of internal medicine of the Midelfart Clinic.

Dr. J. W. Boren, Jr., Succeeds Father as City Health Officer

Recently appointed city health commissioner of Marinette was *Dr. J. W. Boren, Jr.*, who succeeds his father, the late *Dr. J. W. Boren*. Doctor Boren is a member of the staffs of the Boren Clinic and the Marinette General Hospital.

Menasha Doctor Addresses Visiting Nurses Association

Speaking before the January meeting of the Twin Cities Visiting Nurse Association in Neenah on January 24, *Dr. William Hildebrand* of Menasha pointed out the dangers of socialized medicine. He stressed that compulsory health insurance is the "concern of every individual in the United States," and cited the number of new drugs and treatments discovered recently, the lowered death rate from communicable diseases, and the increased life expectancy acquired under the present system of medical care.

Dr. W. J. Fencil Resigns Command of National Guard Unit

Dr. Wayne J. Fencil, Monroe, a major in the medical corps, recently resigned as commanding officer of the Monroe medical platoon of the National Guard. It was announced that "Major Fencil is honorably separated from the military service of the state of Wisconsin effective as of Feb. 8, 1950, on account of business engagements incompatible with efficient military service." He is on the staff of the Monroe Clinic.

Delegates to General Practitioners Meeting Listed

Wisconsin delegates to the 1950 convention of the American Academy of General Practice, held in St. Louis in February, were *Drs. E. L. Bernhart* of Milwaukee and *Milton L. Kulis* of Green Bay. Their alternates were *Drs. George N. Pratt* of Menasha and *Donald C. Ausman* of Milwaukee.

Staff of New Richmond Hospital Organizes

Dr. O. Hoyt Epley, New Richmond, was elected chief of staff of the Holy Family Hospital in that city when the staff held its organizational meeting at the hospital on January 30. *Dr. J. P. Healy* will serve as secretary.

Industrial Clinic Reservation

State Medical Society
704 E. Gorham Street
Madison, Wis.

Date _____

Gentlemen:

I will attend the Industrial Clinic at *(Check Clinic You Will Attend!)*
- Kohler, April 13 ____
- Wis. Rapids, April 20 ____
- Milwaukee, May 3 ____

My check for the dinner is attached: Kohler and Wisconsin Rapids: $3.00
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Send my dinner ticket to the street address indicated.

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AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. O. O. Meyer Appointed Overseas Medical Consultant

O. O. MEYER

Dr. Ovid O. Meyer, professor of medicine at the University of Wisconsin Medical School, was recently named an overseas medical consultant for the Army, according to an announcement from Surgeon General R. W. Bliss. Doctor Meyer, who is president of the Dane County Medical Society, will leave on May 10 for a tour of duty in Europe.

Janesville Physician Certified by Specialist Board

Dr. Everett Reinardy, Janesville physician, was recently certified as a diplomate of the American Board of Surgery. The doctor has been associated with the Munn–Koch Clinic at Janesville since 1945, except for a two year period spent in a surgical residency at Mercy Hospital, Chicago.

Thirteen Physicians Attend Postgraduate Course in Cardiology

In order to familiarize themselves with every aspect of heart disease, thirteen physicians attended a postgraduate course in cardiology at the University of Wisconsin medical School, February 13–17. The course, conducted by *Dr. Herman Shapiro*, chairman of the department of cardiology, was presented in connection with American Heart Week. As part of the program, physicians were conducted through the Kiddie Camp rest home for patients with rheumatic fever. Those attending included *Drs. Henry H. Alderfer* and *N. A. Hill*, Madison; *John J. Mulvaney*, Winnebago; *Lloyd S. Kellogg*, Oregon; *George R. Barry*, Monroe; *Kenneth Manz*, Neillsville; *Walther W. Meyer*, Medford; *Karl H. Doege*, Marshfield; *J. W. Christofferson*, Shawano; *Russell A. Oldfield*, Eagle River; *Woodruff Smith*, Ladysmith; Kenneth Hoel, Aurora, Ill., and Francis G. Dickey, Baltimore.

Madison Physician Speaks at Delavan Convocation

R. C. PARKIN

Members of the Delavan and Rock River Valley chapters of the International Council for Exceptional Children heard a talk by *Dr. Robert S. Parkin*, Madison, when they gathered for a joint dinner meeting at the Colonial Hotel in Delavan on January 26. Doctor Parkin, coordinator of medical education at the University of Wisconsin Medical School, discussed various problems in mental health, primarily the attitude of lay persons toward those with psychosomatic illnesses. He said that the University of Wisconsin is planning graduate courses in mental health and psychosomatic medicine on its program for refresher education for physicians.

Madison Doctors Address Hospital Alumnae Meeting

Two Madison physicians—*Drs. Maxine Bennett* and *Margaret Prouty*—addressed a meeting of the Madison General Hospital Alumnae Association at McConnell Hall, Madison, on January 19. They gave an account of their latest mountain climbing trip, illustrating it with movies, and displayed some of the equipment used.

SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

Dr. J. H. Houghton of Wisconsin Dells was elected president of the Columbia–Marquette–Adams County Medical Society when the organization held its annual business meeting at the Divine Savior Hospital

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(1) Lyon, R. A.: Am. J. Obst. & Gynec. *47*: 532, 1944. (2) Groper, M. J., and Biskind, G. R.: J. Clin. Endocrinol. *2*:703, 1942. (3) Wiesbader, H., and Filler, W.: Am. J. Obst. & Gynec. *51*:75, 1946.

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in Portage on January 17. Serving with Doctor Houghton will be *Drs. R. F. Inman*, Montello, president-elect; and *H. A. Winkler*, Pardeeville, secretary.

Rock

A round-table conference on blood banks was conducted at the January 24 meeting of the Rock County Medical Society, held at the Country Club in Beloit. Members of the panel included two Milwaukee physicians, *Dr. Tibor J. Greenwalt*, medical director of the Junior League Blood Center of Milwaukee, and *Dr. Norbert Enzer*, pathologist at Mount Sinai Hospital; two Chicago doctors, Drs. John M. Whitney, area medical director and assistant manager of the American Red Cross, and Coye C. Mason, director of the Chicago Blood Donor Service; and Dr. Herbert R. Brown, Jr., director of the Rochester, New York, Regional Blood Center and professor of medicine at the University of Rochester School of Medicine. Moderator for the discussion was Dr. A. R. K. Matthews, pathologist at St. Anthony's Hospital at Rockford, Ill.

TWELFTH DISTRICT NEWS

Dr. C. W. Eberbach Named Department Director at Marquette University

C. W. EBERBACH

Dr. Carl W. Eberbach was recently named clinical professor and director of the department of general surgery of the Marquette University School of Medicine, succeeding *Dr. Frederick A. Stratton*. Doctor Stratton retired some time ago following forty-three years of service at Marquette, to devote full time to his private practice. Doctor Eberbach, who is also chief of staff at Milwaukee Hospital and president of the Wisconsin Surgical Society, has been a member of the staff for twenty-two years.

Physicians Participate in Concert Opening Heart Drive

The Milwaukee Musicians Union, under the direction of *Dr. R. O. Brunkhorst*, on January 29 presented a concert in the Crystal Ballroom of the Hotel Schroeder, in observance of the opening of the fund drive of the Wisconsin Heart Association. *Dr. Edward J. Kiefer*, baritone, was a soloist on the program, and *Dr. Samuel Rosenthal* served as program commentator. The concert, which was free, was presented by Local No. 8 of the American Federation of Musicians. It was financed by the federation's recording and transcription fund.

Two Milwaukee Physicians to Serve as Overseas Consultants

FORRESTER RAINE

MAURICE HARDGROVE

Two Milwaukee physicians—*Drs. Forrester Raine*, a surgeon, and *Maurice Hardgrove*, an internist—have been appointed overseas medical consultants for the Army this year, according to a recent announcement from Surgeon General R. W. Bliss. Doctor Raine, a diplomate of the American Board of Surgery and an associate clinical professor of surgery at Marquette University School of Medicine, will go to Europe on September 20. Doctor Hardgrove, an associate professor of medicine at Marquette and senior medical consultant for the Veterans Administration, will go to Panama in September.

Milwaukee Doctor Named Secretary of Conference on Medical Service

The National Conference on Medical Service on February 5 elected as its secretary *Dr. Robert E. Fitzgerald* of Milwaukee. The election was held during the twenty-third annual meeting of the organization in Chicago. The group meets during the annual conference of the Congress on Medical Education and Licensure of the American Medical Association to discuss medical-economic problems.

Dr. G. F. Tegtmeyer to Serve as Insurance Medical Aide

Dr. G. F. Tegtmeyer was recently named medical director of the Northwestern Mutual Life Insurance Company, Milwaukee, to succeed *Dr. D. E. W. Wenstrand* of Milwaukee. Doctor Wenstrand will devote full time to completing historical research projects in the medical department before he retires. Doctor Tegtmeyer has been associate medical director of the firm for the past two years, having joined the medical staff in 1936 as assistant medical director.

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Asylum Medical Director Speaks to Golden Age Club Leaders

Dr. Ralph M. Fellows, medical director of the Milwaukee County Asylum, spoke to Golden Age Club leaders at the second of a series of meetings, held in the Municipal Recreation Department Office, Milwaukee, on January 30. He pointed out that aging people need activity, interests, and security, adding that clubs sponsored by the Recreation Department provide these activities through social contacts. He also stated that there is an urgent need for guidance clinics for old people, where men and women over 65 could discuss their problems with qualified persons.

Milwaukee Physician Certified by Specialist Board

Dr. Leonard J. Schwade, Milwaukee physician, was recently certified as a diplomate of the American Board of Proctology, having successfully passed the examination of the Board of Proctology given at Philadelphia in November 1949. Doctor Schwade, a clinical instructor in surgery at Marquette University School of Medicine, served for three years in the Army Medical Corps during World War II.

SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

A member of the department of surgery at the University of Chicago School of Medicine, Dr. Elwood V. Jensen was the guest speaker of the Milwaukee Academy of Medicine at its meeting on February 21 at the University Club of Milwaukee. The doctor discussed "Serum Protein Changes in Cancer."

Milwaukee Neuro-Psychiatric Society

Meeting at the University Club of Milwaukee, members of the Milwaukee Neuro-Psychiatric Society heard speakers from Milwaukee and Madison on February 15. *Dr. George F. Meisinger*, a member of the staff of Sacred Heart Sanitarium in Milwaukee, presented "An Unusual Case of Camptocormia," and *Dr. I. J. Sarfatty*, director of the Veterans Administration Mental Hygiene Clinic in Madison, discussed "Psychogenic Headaches."

SOCIETY RECORDS

New Members

Marvin W. Nelson, 122 West Washington Avenue, Madison.

Joseph Gilbert, 161 West Wisconsin Avenue, Milwaukee.

Change of Name

N. A. Frankenstein, Madison, to N. A. Franken.

James W. Gutschenritter, Milwaukee, to James W. Ritter.

Changes in Address

R. S. Ingersoll, Adams, to 1620 Shore Drive, Beloit.

H. F. A. Colfer, Madison, to Westfield, New Jersey, care of General Delivery.

W. L. Cochrane, Clinton, to 400 East Grand Avenue, Beloit.

J. R. Talbot, Wonewoc, to Wisconsin General Hospital, Madison.

R. J. Jones, Vincennes, Indiana, to 402 S. Yuez Avenue, Monterey Park, California.

H. F. Twelmeyer, West Allis, to 161 West Wisconsin Avenue, Milwaukee.

J. W. Christofferson, Marshfield, to Marsh Clinic, Shawano.

F. N. Nimz, West Allis, to 4751 West Woodlawn Court, Milwaukee.

T. M. Northey, Milwaukee, to 105 W. Silver Spring Drive, Whitefish Bay.

D. W. Calvy, Wauwatosa, to 161 West Wisconsin Avenue, Milwaukee.

R. W. Ramlow, Madison, to 1836 South Avenue, La Crosse.

P. S. Herzog, Kenosha, to Station Hospital, Army Air Base, Las Vegas, Nevada.

H. G. Bayley, Milwaukee, to 124 Winn Terrace, Beaver Dam.

R. P. Embick, Madison, to Hall Building, Coos Bay, Oregon.

T. J. LaSusa, Wauwatosa, to 161 West Wisconsin Avenue, Milwaukee.

E. A. Gecht, Waukesha, to 238 West Wisconsin Avenue, Milwaukee.

G. R. Clarke, Milwaukee, to Wheeling, West Virginia.

J. E. Koepsell, Wauwatosa, to 3216 North Eighty-fourth Street, Milwaukee.

M. G. Apell, Madison, to 21 South Kingsbury Avenue, Gloversville, New York.

R. A. Powell, Kenosha, to 810 Main Street, Racine.

S. S. Sakaguchi, Wauwatosa, to 7061 Whitsett, North Hollywood, California.

H. H. Everett, Green Bay, to 2759 Carlton Place, Milwaukee.

R. E. Schlitter, Eau Claire, to Kingsford Drug Building, Kingsford, Michigan.

A. W. Burek, Wausau, to Jackson Memorial Hospital, Miami, Florida.

Edward Zupanc, Madison, to 608 Medical Arts Building, Duluth, Minnesota.

M. E. Foley, West Bend, to Beaver Dam.

C. M. Akwa, Milwaukee, to 8425 West Center Street, Wauwatosa.

J. M. Beffel, West Allis, to 6514 West Wells Street, Wauwatosa.

William L. Coffey, Jr., Wauwatosa, to 536 West Wisconsin Avenue, Milwaukee.

V. J. Cordes, Milwaukee, to 7405 Harwood Avenue, Wauwatosa.

R. B. Dodd, Milwaukee, to Massachusetts General Hospital, Boston, Massachusetts.

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DEATHS

Dr. Richard Halsey, prominent Lake Geneva physician, died at a Rochester, Minn., hospital on January 10. He was 63 years old.

Born in Oshkosh on October 20, 1886, the doctor attended Rush Medical College, graduating in 1912. He interned at the Kansas City General Hospital, Kansas City, Mo., and established his first practice in Lake Geneva, where he had continued until his recent illness. The doctor was one of the founders of the Lake Geneva Clinic.

Doctor Halsey was a member of the Walworth County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, two sons, and two daughters.

Dr. Roy M. Greenthal, widely known Milwaukee pediatrician, died at a Milwaukee hospital on January 27. He was 54 years old.

Born in Detroit, Mich., on February 26, 1895, Doctor Greenthal received his medical degree from the University of Michigan Medical School in 1918. He interned at the University Hospital, Ann Arbor, Mich., and continued his studies at the New York Nursery and Childs Hospital and Mount Sinai Hospital in New York and at Boston hospitals. From 1920 to 1922 he served as instructor in pediatrics at the University of Michigan Medical School, following which he established his practice in Milwaukee. The doctor was on the staffs of Milwaukee Children's Hospital and Columbia Hospital.

A charter member of the Milwaukee Pediatric Society, Doctor Greenthal was a diplomate of the American Board of Pediatrics and a member of the American Academy of Pediatrics. He also held membership in the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife, a son, and a daughter.

Dr. E. F. McGrath, a practicing physician in Appleton for thirty-three years, died suddenly on February 3, while vacationing at Sebring, Florida. The doctor was 61 years old.

Born at Chilton on April 6, 1888, the doctor received his degree in medicine from Marquette University School of Medicine in 1912. Following internship at St. Elizabeth Hospital, Appleton, he practiced in Wrightstown for a time before entering practice in Appleton. Since 1926 he had been the roentgenologist at St. Elizabeth Hospital. President of the active staff in 1921, the doctor had served on the executive staff of the hospital since 1935. A captain in the Army Medical Corps during World War I, he had served as head of the Outagamie County Selective Service Board during World War II. For a long time, he had also been medical examiner for the Appleton units of the Wisconsin National Guard.

Doctor McGrath was a member of the Radiological Society of North America, the Outagamie County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, his mother, a daughter, five sisters and two brothers.

Dr. J. J. Looze, a life member of the State Medical Society and a charter member of its Fifty Year Club, died at his home in Wisconsin Rapids on February 17, at the age of 88. The doctor had practiced medicine for sixty years, fifty of them in Wisconsin Rapids.

Doctor Looze was born in the town of Lincoln, Kewaunee County, on October 6, 1861. Following graduation from the Chicago Pharmaceutical College, he worked for a short time as a pharmacist in Green Bay before entering Rush Medical College, Chicago. Graduating in 1889, he returned to Kewaunee County to establish his first practice. After eight years he moved to Seymour, where he practiced for a year and a half before locating in Wisconsin Rapids. He retired from active practice in 1948. For thirty-seven years he had served as medical examiner for the Metropolitan Insurance Company, and for many years prior to his retirement he had been a surgeon for the Chicago, Milwaukee, St. Paul and Pacific Railroad and for the Lutheran Aid.

A life member of the State Medical Society, the doctor also held membership in the Wood County Medical Society and the American Medical Association.

Survivors include his wife, a daughter, and a son.

Dr. Paul M. Clifford, Green Bay physician for thirty years, died at a hospital in that city on February 17. He was 56 years old.

Doctor Clifford was born in Iron Mountain, Michigan, on March 20, 1893. He received his medical degree from Marquette University School of Medicine in 1916, and following service with the Army Medical Corps during World War I, served with the American Army of Occupation for a year. He completed his internship at the Detroit General Hospital before entering the practice of medicine in Green Bay in 1919.

A member of the American Legion, the doctor also held membership in the Brown–Kewaunee–Door County Medical Society, the State Medical Society, and the American Medical Association.

Doctor Clifford is survived by his wife, a son, and a grandson.

Dr. Chester M. Echols, prominent Milwaukee physician and surgeon, died suddenly after performing an operation at a Milwaukee hospital on February 20. The doctor, who had practiced in Milwaukee for forty-five years, was 75 years old.

A native of McLeansboro, Illinois, the doctor was born on June 15, 1874. He attended Rush Medical College, receiving his M.D. degree in 1901. He also studied in Edinburgh, Berlin, and Vienna, entering practice in Appleton in 1903. After two years he moved to Milwaukee, where he served as professor

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of gynecology at Milwaukee Medical College for eight years.

In 1936 Doctor Echols served as president of the Medical Society of Milwaukee County, and for the succeeding five years he was on its board of directors. A fellow in the Chicago chapter of the American College of Surgeons, he also held membership in the State Medical Society and the American Medical Association.

Survivors include a daughter and two sons.

Dr. Edward P. Carlton, physician and eye specialist in the DeForest area for the past forty-one years, died at his home in DeForest on February 10. He was 78 years old.

Born in Milwaukee, the doctor attended the University of Wisconsin and, following graduation in 1894, served for a year as an instructor in the biology department. In 1896 he entered Northwestern University Medical School, where he received his degree in medicine in 1899. He spent a year in the Illinois Eye and Ear Infirmary in Chicago, and also was an associate professor of ophthalmology at Northwestern University Medical School for three years. His first practice was established at Keyser, and this was followed by five years in Twin Brooks, South Dakota, before he returned to the DeForest area in 1915.

The doctor was a member of the Fifty Year Club of the State Medical Society and of the Dane County Medical Society and the American Medical Association. In 1942 he was elected an honorary life guest of Edward Olson Post No. 348 "Because of his outstanding service to the community and his loyalty to the ideals and purposes of the American Legion."

He is survived by two daughters.

CORRESPONDENCE

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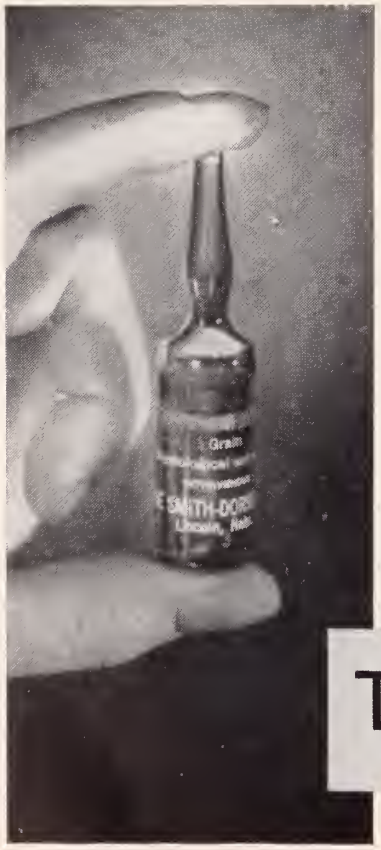
February 8, 1950

Dear Mr. Thayer: I would like to express my personal appreciation and that of the College of Agriculture for your assistance in helping make our recent Farm and Home Week program a success. Dr. Franklin D. Murphy's address on "Where Are the Doctors and Why?" was very well received by the rural audience. They also appreciated the splendid exhibits which you provided.

Sincerely yours,
(Signed) RUDOLPH K. FROKER
Dean and Director



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Some Winter Activities of the Woman's Auxiliary

Marinette

A holiday ball was sponsored by the Marinette county auxiliary for the young people of the community. Marinette county auxiliary meets four times a year.

Douglas

The Douglas County Auxiliary installed its new officers in January. They were: Mrs. Herbert Christianson, president; Mrs. Fred G. Johnson, president-elect; Mrs. Ralph Anderson, secretary-treasurer; and Mrs. James McGill and Mrs. Thomas Doyle in charge of bringing the Douglas county archives up to date. Socialized medicine was discussed at the February meeting, led by Mrs. Roger Thompson, Superior.

Fond du Lac

Donations were allotted to the March of Dimes, Heart Association, and Cancer Fund at a dinner meeting of the Fond du Lac County Auxiliary in January at the home of Mrs. F. J. Cerny, with Mrs. E. V. Smith, Jr., presiding. Miss Ruth Basler spoke on therapy for polio patients and a movie was shown exhibiting work done in that field. Thank-you letters were read from a Dutch family to whom the Auxiliary had sent four boxes of clothing at Christmas time, and from the Fond du Lac County Hospital, where gifts were provided during the holiday season. Miss Ruth Werner of Chicago, daughter of Mrs. H. C. Werner of Fond du Lac and the late Doctor Werner, spoke informally.

Dodge

In December the Dodge County auxiliary sponsored a dinner-dance for the doctors of the Medical Society and their wives. During that month toys were collected and turned over to the county nurse for distribution, and baskets of homemade cookies and jams, candy and salted nuts were sent to the Sisters at the hospitals.

Winnebago

Under the direction of Mrs. Behnke, program chairman, Miss Helen Wahoski of the faculty of Oshkosh State Teachers' College spoke to the Winnebago Auxiliary and showed slides of her recent trip to Switzerland, where she spent some time studying at the University of Fribourg. This was a luncheon meeting at the Athearn hotel, Oshkosh. Twenty-seven members were present, and Mrs. James Murphy, Winnebago, was their guest.

PHYSICIAN-ARTISTS TO HOLD EXHIBITION AT A. M. A. CONVENTION

The American Physicians Art Association will hold its twelfth art exhibition in conjunction with the American Medical Association Convention at the San Francisco Auditorium June 26–30. Any physician having fine or applied arts as a hobby may exhibit by becoming a member of the Art Association and applying for entry blanks and shipping labels of the secretary F. H. Redewill, M. D., 526 Flood Building, San Francisco 2, California. Over one hundred trophies will be awarded to advanced physician artists as well as to beginners (who have done art work less than two years).

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The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal* "Bookshelf," are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Practical Aspects of Thyroid Disease. By George Crile, Jr., M.D., F. A. C. S. Department of Surgery, Cleveland Clinic. Philadelphia and London: W. B. Saunders Company, 1949.

In "Practical Aspects of Thyroid Disease" by George Crile, Jr., the author draws on his experiences with some thousand cases of thyroid disease for his material. As the title implies, only those points which are of practical use to the clinician, and generally accepted, are incorporated, while the controversial and little understood problems are purposely withheld. Much of the material in the book is not new and follows the teaching as carried out in most good clinics. The physiology of the thyroid gland is presented in a clear and simplified fashion. The use of the new thiouracil drugs alone and in combination with iodine is thoroughly covered. The preoperative and postoperative care of thyroid patients, along with a description of the surgical technics, as practiced at the Crile Clinic, is complete but really adds nothing new. The new radioactive iodine compounds and their use in the management of hyperthyroidism is fully discussed. No small part of the book is devoted to malignancies of the thyroid gland and their management.

The book is intended for the internist as well as the surgeon. It is recommended especially as a reference book for the general surgeon's library.—B.W.M.

Campbell's Operative Orthopedics. Edited by J. S. Speed; associate editor, Hugh Smith, M. D. Second edition. 2 volumes. With 1,141 illustrations, including 2 color plates. St. Louis, The C. V. Mosby Company, 1949. Price $30.00.

This long-awaited edition of "Campbell's Operative Orthopedics" has fulfilled its promise of a completely new, authoritative compilation of orthopedic technics. Unlike many second, so-called "revised," editions, these volumes represent a substantial improvement over the first in vision, content, and usefulness. Several new chapters and sections have been added in the light of recent advances, and the text has been enlarged to include preliminary data and influencing factors to direct the resident or fellowship man in the sound choice of procedure in a given orthopedic situation.

The same general and satisfactory outline has been followed, with operative methods grouped in accordance with their applicability to a given affection, and the technics included may be said to have been "kitchen-tested."

The bibliography, illustrations, and indexes of authors and subjects are excellent, and the pleasing physical properties of these volumes make this work one not to be easily equalled.—H.I.O.

Obstetric Analgesia and Anesthesia; Their Effects upon Labor and the Child. By Franklin F. Snyder, M.D., Associate Professor of Obstetrics and Associate Professor of Anatomy, Harvard Medical School. Pp. 401, with 114 figures and 18 tables. Philadelphia and London, W. B. Saunders Company, 1949. Price $6.50.

". . . the cardinal function of labor is the birth of living offspring, . . ." This statement of the author, coupled with his proper concern for the welfare of the mother, presents the deep running current of thought behind the large and comprehensive accumulation of data gathered under one cover in this text. There is presented a challenging originality in combination with a studied tabulation of clinical, experimental, and statistical results of past experience from a wide range of sources as well as the author's own varied background. The basic concept of normal intrauterine fetal respiration is documented with force and is supported by special observations on rabbit fetuses under experimental conditions simulating the normal environment of the fetus before birth in a manner not previously achieved. Unfortunately for the reader, some portions of this thesis are written in a repetitious, difficult, and lengthy style which might discourage or limit an audience not so keenly interested in the inherent subject matter dealing with analgesia and anesthesia in labor. The second section of the book

turns a more practical and clinical eye to the treatment of pain during labor. Of special interest are the fundamental problems of asphyxia and the author's contention that the most serious adverse effects of morphine are exerted on the mother's labor mechanism to cause indirect harm to the fetus rather than by direct action on the newborn infant himself. Summary outlines at the end of each chapter are assets to the book. Extensive bibliographies offer sources for further exploration by the interested reader. Thus, despite some handicaps in form and clarity, this book represents a useful source of material on a subject of wide interest to many physicians.

Oral Anatomy. By Harry Sicher, M.D., professor of anatomy and histology, Loyola University School of Dentistry, Chicago College of Dental Surgery. With 310 text illustrations, including 24 in color. St. Louis, The C. V. Mosby Company, 1949. Price $15.00.

The term "Oral Anatomy" as a title for the new book written by Dr. Harry Sicher of Loyola University School of Dentistry is a gross understatement in light of the actual contents of the book. The title could well include reference to physiology, histology, and surgical anatomy of the head and neck. Since Doctor's Sicher's prime field of research has always been directed to the oral cavity, it is presumed that this is the focal point of his text from which all the other information seems to radiate. One must know Doctor Sicher to appreciate fully the text. The book is like reading a transcript of his lectures.

The book is unusually well presented and illustrated. His supposedly uninteresting subject of anatomy is highlighted by unorthodox methods of presentation on such subjects as the temporomandibular joints and the fascia of the neck. It is of interest to all in the fields of surgery, physiology, medicine, and dentistry. He does not limit his definition of anatomy to the cut and dried understanding of static studies, but includes dynamic forces of his own interpretation as related to growth and development—particularly true in the growth of the skull itself, growth of the upper and lower jaws, and the very complicated relationship of the temporomandibular joint to this general growth process. There are very adequate discussions of other related subjects, but the presentation of this phase by this author makes one appreciate his concept of the subject. The most interesting and most thoroughly different phase of this whole problem is his description of the fascia of the head and neck. His opening description of the fascia of the neck is as follows: "The descriptions of the cervical fasciae are utterly confusing. The confusion in definition and nomenclature is mainly caused by neglect of the functional aspects which underlie the formation of a fascia." It is with this statement that he goes ahead and builds his inter-

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pretation of the development and function of the fascia of the neck. I think it is his particular interpretation of fascia, as it is related to function, that makes his interpretation of the gross aspects of anatomy more practical. After reading his descriptions of the fascial layers it makes it more easily understood why complications that once were unexplainable extending fascial plane infections in the neck act as they did.

Sicher is not only a teacher paramount in his field but reaches equal stature in the field of research. This combination plus the ability to evaluate the practical application of knowledge acquired and ability to present it in print is the highest recommendation this reviewer can give.—W.B.S.

Blood Transfusion. By Elmer L. DeGowin, M. D., associate professor of internal medicine, State University of Iowa; Robert C. Hardin, M. D., assistant professor of internal medicine, State University of Iowa; and John B. Alsever, M. D., senior surgeon, United States Public Health Service. Pp. 587, with 200 diagrammatic drawings. Philadelphia and London, W. B. Saunders Company, 1949. Price $9.00.

This is an excellent preparation which is highly recommended to all individuals interested in the transfusion of blood and blood derivatives.

The book is divided into 9 parts as follows: historical perspective; clinical use of blood and its derivatives; immunology of blood; technical section; transfusion of whole blood; preparation and administration of plasma; preparation and administration of the blood derivatives and plasma substitutes; transfusion services; and transfusion apparatus.

It should be specially mentioned that the authors are internists with a rich experience in both the laboratory and the clinical aspects of this field. —W. H. J.

Normal Values in Clinical Medicine. By F. William Sunderman, M. D., Ph. D., professor of experimental medicine and clinical pathology, University of Texas Postgraduate School of Medicine; and Frederick Boerner, V. M. D., late associate professor of clinical bacteriology, Graduate School of Medicine, University of Pennsylvania. Pp. 845, with 237 figures and 413 tables. Philadelphia and London, W. B. Saunders Company, 1949. Price $14.00.

Physicians and workers in allied sciences are always concerned with the need for measurements and values that constitute the normal. This is the first book which collects such data into a comprehensive unit. Subjects covered include normal values pertaining to nearly every organ system (heart, respiratory tract, digestive, etc.), to tests of function of various organs, concluding with tables on standards for metabolism, growth and nutrition, to mention a few. The book should prove extremely useful as a reference for this type of increasingly complex and detailed information.—E. C. A.

Meet Senator Murray, Doctor!

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THE WISCONSIN MEDICAL JOURNAL

P. S. PAGE 258 LISTS THIS MONTH'S ADVERTISERS.

Trade News

Former Marquette Professor Joins Staff of Ames Company

Owing to the broad expansion in Ames Company, Inc.'s, product development program, Dr. Max Gilbert joined Ames Company February 1 as medical director, with Dr. R. L. Conklin continuing as research and medical director in addition to his duties as director of the corporation.

Doctor Gilbert has a broad background in the pharmaceutical and drug industry. For eight years he was assistant professor of chemistry at Marquette University, Milwaukee, teaching organic chemistry and biochemistry. He received his M. D. at Northwestern University Medical School in 1932, serving his internship and holding a residency at St. Luke's Hospital in Chicago. For eight years he served in the medical department of the Schering Corporation and later was employed as medical director by Wm. R. Warner Company and by Bilhuber–Knoll Corporation.

Schering Award Subject For 1950 Announced

The currently important problem fascinating medical research workers today, "The Clinical Use of Steroid Hormones in Cancer," will be the subject of The Schering Award for 1950.

The Schering Award is conducted annually for students in the medical schools of the United States and Canada. Medical students enter the competition by preparing a manuscript on the designated subject in the field of endocrinology. Manuscripts are judged by three prominent endocrinologists. Cash prize awards of $1000, $500, and $300 are offered.

As a result of gaining a thorough knowledge of the subject of his study, the medical student acquires better judgment of his own cases in future practice. The benefit to students is recognized by the deans of medical schools as well as by the participants. Representation in the contest from practically every medical school is anticipated.

Sponsor of the award is Schering Corporation of Bloomfield, N. J., pioneer in the development of potent endocrine preparations and research. The Schering Award is conducted each year for the purpose of enlarging student knowledge of endocrinology.

Sodium-Free Salt Substitute Being Made Available at Drug Store Fountains in Shakers, Unit Packets

A nation-wide campaign has been launched by Winthrop–Stearns, Inc., to promote the use of Neocurtasal, a sodium-free salt substitute, at drug store soda fountains throughout the country, for the benefit of those who have been directed by their physicians to abstain from the use of ordinary table salt for various reasons.

To stimulate this campaign for immediate patient availability, W. E. Sowersby of the sales division for Winthrop–Stearns has announced a complete merchandising program for Neocurtasal available to individual retailers and to chain drug stores. This promotion includes the 2-ounce shaker for counter use, attractive fountain strip signs and menu tabs noting the availability of this sodium-free salt substitute, individual packets for one-meal use, and special display cartons of six 2-oz. shakers.

"Tests in spot cities last year revealed enthusiastic interest and wholehearted cooperation on the part of retailers," Mr. Sowersby said, "and we see that such a campaign will advance the relationship between the public which requires a salt-free diet and the fountain managers who make Neocurtasal available to them."

Neocurtasal is now being offered in small unit packets which contain enough salt-substitute for the average meal. Travelers and institutions will find these packets especially convenient. Neocurtasal also comes in 8-ounce bottles.

This product is indicated "for salt (sodium)-free diets in cardiac diseases, particularly when associated with edema, hypertension, arteriosclerosis and fluid retention in pregnancy," according to Winthrop–Stearns Inc. It is also employed by many physicians as a part of weight-reducing regimens. There are about 13,000,000 people in the United States today who at one time or another require salt-free diets, medical statisticians reveal.

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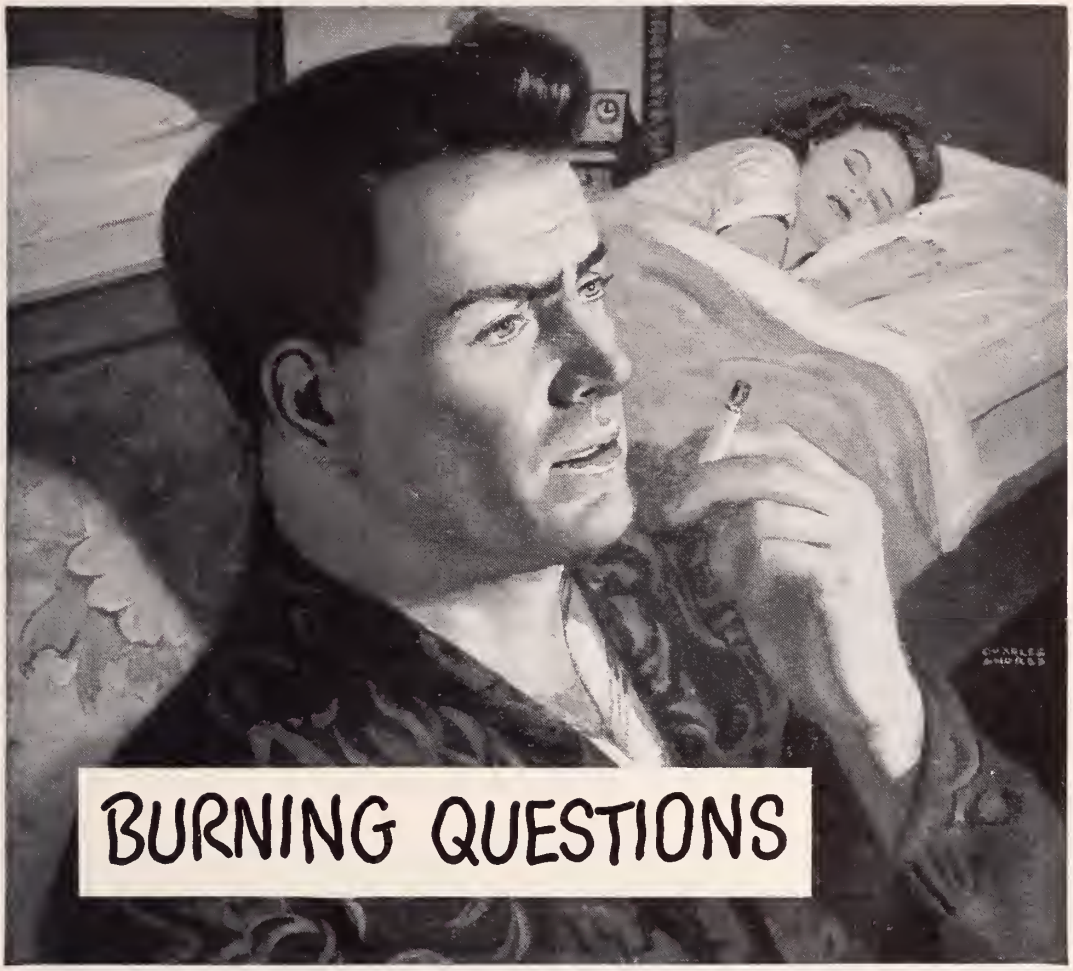

Late at night, some men do their hardest worrying. Each thought glows like the burning end of a cigarette. Chain-thoughts like:

"How am I doing my job? Have I reached my top? Are my best earning years numbered?

"And how will that affect my other job—as husband, father, family provider? Will I be able to do the things we've planned? What about college for the children? And our home—will I always be able to meet payments?"

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Coming Events

University of Minnesota Schedules Continuation Courses

The University of Minnesota announces a continuation course in pediatrics on April 10–12, 1950. This course, which will be presented at the Center for Continuation Study, is intended for physicians specializing in pediatrics and will be devoted to disorders of metabolism and endocrine function.

Distinguished visiting physicians who will participate as faculty members for the course are Dr. Daniel C. Darrow of Yale University School of Medicine, New Haven, Conn., and Dr. George M. Guest, Children's Hospital, Cincinnati, Ohio. The remainder of the faculty for the course will be made up of clinical and full-time members of the staff of the University of Minnesota Medical School and the Mayo Foundation.

A continuation course in gynecology for doctors of medicine engaged in private practice will be presented at the Center for Continuation Study on April 17–19. Among the subjects to be considered are uterine bleeding, inflammation of the cervix uteri, urinary incontinence, and lesions of the vulva.

A continuation course in cardiovascular diseases will be presented for general physicians on April 20–22. The course is sponsored by the Minnesota Heart Association, the Minnesota State Medical Association, and the Minnesota Department of Health. A limited number of Minnesota physicians will attend as guests of the Minnesota Department of Health. It is hoped that this course will accommodate the large number of physicians who could not be accepted for a similar course which was given in January.

On May 22–27, a continuation course in proctology will be presented, with Dr. George Thiele of Kansas City the visiting faculty member. He will discuss "The Relationship of Anorectal Diseases to General Medical Problems" and "Office Management of Common Proctologic Complaints."

Throughout the course emphasis will be placed on those anorectal and colonic lesions most frequently seen by practicing physicians. The presentation will be by means of lectures, operative clinics, motion pictures, and seminars. Faculty for the course will be made up of clinical and full time members of the staff of the University of Minnesota Medical School and the Mayo Foundation.

A symposium on hypertension will be presented on the campus of the University of Minnesota on September 18–20, in honor of Doctors Elexious T. Bell, Benjamin J. Clawson, and George E. Fahr. Doctors Bell and Clawson retired from the department of pathology in June 1949 and Doctor Fahr will retire in June 1950 from the department of medicine.

A symposium on hypertension in honor of these men is appropriate since all three have had special interest in this disease. The symposium will bring to the University distinguished scientists from the United States and abroad. Support for the symposium has been provided by the Variety Club, the Mayo Foundation, and the Univeristy of Minnesota. All interested physicians will be welcome to attend.

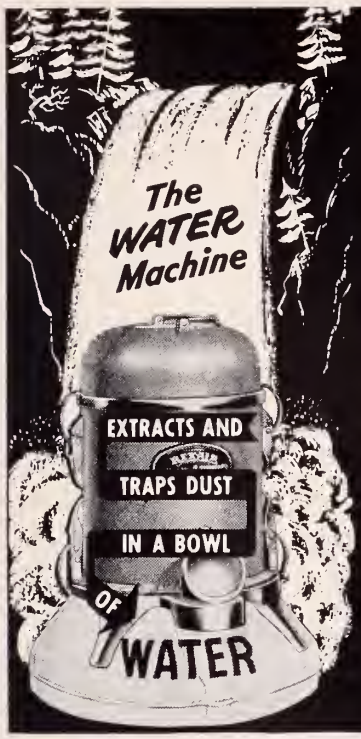
International Congress on Chest Diseases Scheduled

The First International Congress on Diseases of the Chest will be held at the Carlo Forlanini Institute, Rome, Italy, September 17–20, under the auspices of the Council on International Affairs of the American College of Chest Physicians and the Carlo Forlanini Institute, with the patronage of the High Commissioner of Hygiene and Health, Italy, in collaboration with the National Institute of Health and the Italian Federation Against Tuberculosis.

Physicians who are interested in attending the Congress should communicate at once with Dr. Chevalier L. Jackson, Chairman of the Council on International Affairs, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois, or with Professor A. Omodei Zorini, Carlo Forlanini Institute, Rome, Italy.

American Congress of Physical Medicine to Meet

The American Congress of Physical Medicine will hold its twenty-eighth annual scientific and clinical session August 28–September 1, inclusive, at the Hotel Statler, Boston. Scientific and clinical sessions will be held. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction seminars will be held August 28–31. These seminars will be offered in two groups: One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.



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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: A young physician assistant in general practice in central Wisconsin. Hospital facilities available. Address replies to No. 276 in care of the Journal.

WANTED: General practitioner in a village of about 1,000. No competition. Office available. Prospects of a hospital within a year. Address replies to No. 258 in care of the Journal.

AVAILABLE: Excellent opening for young doctor in prosperous community in northwestern part of Wisconsin. Hospital facilities available. Possibilities of permanent position in clinic. Scandinavian preferred, though not necessary. If interested, write qualifications. Address replies to No. 282 in care of the Journal.

FOR SALE: Ophthalmologist–otolaryngologist wishes to sell forty year old established practice located in an industrial area of Milwaukee. Doctor agrees to work with buyer until business is secure. Address replies to No. 283 in care of the Journal.

AVAILABLE: Radiologist, aged 31, Wisconsin license. Eligible for Boards in both diagnosis and therapy. Completing three-year training in large teaching institution. Available July 1, 1950. Address replies to No. 279 in care of the Journal.

FOR SALE: Instruments and supplies of deceased physician. Includes sun lamp with infra-red and ultraviolet bulbs, x-ray shadow box 14 by 17", surgeon's x-L Lyte, Clintest urine-sugar analysis set, Spencer HB-meter, ophthalmoscope, hypodermic syringes, standard catheters, surgical instruments, and a few drugs. Address replies to No. 281 in care of the Journal.

INTERNIST, age 34, married, desires association with group or established internist or surgeon. Three year approved residency. Board eligible in August. Address replies to No. 284 in care of the Journal.

FOR SALE: Practice of deceased physician, including supplies and office furniture in village of 1,000 in center of rich agricultural district. Address replies to No. 285 in care of the Journal.

FOR SALE OR LEASE, or will employ with option of buying: Well established E. E. N. T. practice in Milwaukee. Refraction constitutes large portion of income. Address replies to No. 286 in care of the Journal.

PHYSICIAN AVAILABLE: Desire to associate with doctor or clinic in Milwaukee for evening office work. Trained in internal medicine. Call Dr. J. E. Gruender, Hilltop 5-6089.

WANTED: Physician as associate with two other doctors in city of about 5,000 in east central Wisconsin. Fine hospital. Excellent opportunity. Address replies to No. 287 in care of the Journal.

ENTIRE HOSPITAL CONTENTS FOR SALE: At one-half price, all A-1 condition; *(a)* 11 beds, mattresses, gowns, bedpans, kitchen equipment, dishes utensils, catgut, 4 bassinettes, all of general hospital equipment line $3,000 worth for $1,500; *(b)* operating table, obstetric table, surgical instrument table, operating light, for $500; *(c)* surgical instruments, ample for four major surgicals per forenoon, value $8,000 A-1 condition, good as new, obtainable for $5,000. Must be purchased as entities to consummate sale at these figures; total price for entire lot, a, b, and c, if taken, $6,500 cash, otherwise, as listed above; a real value to replace your stock equipment or for beginning your own hospital. Address replies to No. 295 in care of the Journal.

WANTED TO BUY: Tilt table for proctoscopic examinations. John A. Tasche, M. D., 809 North Eighth Street, Sheboygan, Wisconsin.

WANTED: Young physician for general practice in small Scandinavian community in Wisconsin, to associate with progressive clinic group. Excellent hospital facilities. Partnership arrangement. Address replies to No. 291 in care of the Journal.

WANTED Immediately by midwestern group: Surgical assistant and urological assistant. Salary $400 per month. Minimum requirements: rotating internship. Address replies to No. 292 in care of the Journal.

CLINIC FOR SALE: Fifty-one year old clinic on Main Stret. "Femineered" (for two female M. D.'s or preferably male and female M. D.'s). Drawing from 8 villages and one city, 30,000 drawing territory. Close to large cities; modern 17 room clinic, completely furnished for all diagnostic and treatment work; nominal rental, $100 per month; all equipment less than 5 years old: x-ray, BMR, Ekg, etc. Physiotherapy, laboratory, prescription department, 6 exam rooms, storage rooms, files, business office, 30 reception chairs, patient load average 60 daily. In city of 5 factories and best dairying; 4,000 active accounts; $40,000 gross yearly; 300 OB's and major surgicals yearly. Sell for inventory $20,000 plus $5,000 for expendables and $3,000 for good will and thorough introduction to make practice secure; hospitals nearby approved; competition no factor to well trained M. D.'s; must pay for expendables at once, balance terms as desired 6 per cent. This practice buys itself in less than one year; obtain own associates; enough practice for 3 M. D.'s Practice sale after Jan. 1, 1951, but can associate earlier. Further details available to bona fide applicants who can present security on required equity on above practice. Apartment or house available, optional. Specializing. Contract sale available. Address replies to No. 293 in care of the Journal.

FOR SALE: Solo practice: Village of 500, no M. D. (deceased); 25 year old practice in territory of 3,000, can net $10,000 yearly if willing to work. 5 room fully equipped first floor medical building. Building and all equipment, file, prescription department complete, 600 active accounts, complete set-up for $6,000; overhead ridiculously low (taxes and insurance $50 a year: heat $100 a year; miscellaneous $100 a year); consists of 2 examination rooms, laboratory and physiotherapy, prescription room, waiting room with usual furnishings. No druggist, must fill own prescriptions; "permit" pharmacy in town; practice now being held by part time nearby practitioner who wishes to leave to specialize; two hospitals nearby; in northern Wisconsin near cities; hunt, fish at back door. $2,000 down, balance terms 6 per cent; over half of equipment is less than 5 years old. Rest is A-1 condition. Address replies to No. 294 in care of the Journal.

FOR SALE: Waterless McKesson basal metabolor, used only about ten times. In excellent condition; small oxygen tank, one third full, with machine. Address replies to No. 289 in care of the Journal.

FOR SALE: General practice. Owner retiring after 39 years in the same location in northeast Wisconsin community of 3,500. Home, office, and equipment for sale. Good location, good schools and churches. Can easily be made a partnership. Address replies to No. 290 in care of the Journal.

WANTED: Young practitioner interested in obstetrics. Excellent opportunity. Housing available. Address replies to No. 296 in care of the Journal.

AVAILABLE: Office, with equipment for sale; doctor retiring. Good location in city of 7,000 in southern Wisconsin with new hospital. Address replies to No. 288 in care of the Journal.

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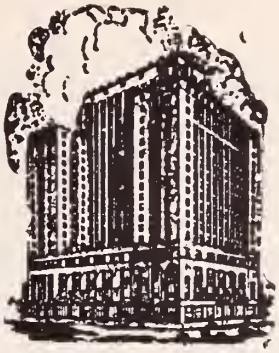

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The
MEDICAL FORUM

The Wisconsin Medical Journal March, 1950

DR. GUNDERSEN OPPOSES H.R. 6000 AT SENATE HEARING

DR. OSBORN HEADS MENTAL PROGRAM

Madison, Mar. 11.—University of Wisconsin regents have approved the integration of the mental hygiene division of the state board of public welfare and the Wisconsin Psychiatric institute of the University medical school, and named Dr. Leslie Osborn, head of the University of Buffalo psychiatry department, as director of the joint program.

Was Society Recommendation

This action was in line with recommendations made last year by the State Medical Society's committee on mental hygiene.

Dr. William F. Lorenz, present director of the psychiatric institute, who is within a few years of retirement age, will continue his current functions related primarily to the laboratory services of the institute.

The regent vote gives the go-ahead to a committee to maintain a close relation between the medical school and the board of public welfare in planning resident training in psychiatry and other post-graduate teaching; for preserving good medical care and treatment for the mentally ill at Mendota, Winnebago and county hospitals, and in preserving mental health throughout the state.

VA CUTBACK HITS WISCONSIN

Madison, March. 3.—The Veterans Administration has announced an over-all economy program that will cut out 7,800 jobs nationwide, and will eliminate four of the seven VA medical and dental clinic offices in Wisconsin.

The reduction in force, the first to hit VA medical personnel, is prompted by a shortage in funds for the balance of 1950 and the necessity of meeting provisions of the 1951 budget.

Almost 200 persons will be dropped from VA payrolls in Wisconsin as a result of the cutback. VA offices in La Crosse, Superior, Wausau and Racine will be closed. Only the offices in Milwaukee, Madison and Green Bay will remain open. The separation of employees is to be effective April 10, 1950.

WILLIAM L. LEA

Prof. Lea Takes Over Industrial Hygiene Post

Madison, March 1.—William L. Lea, Madison, assistant professor of civil engineering at the University of Wisconsin, has been appointed director of the division of industrial hygiene in the state board of health, Dr. Carl N. Neuport, state health officer announced recently.

Professor Lea will fill the position which has been vacant since the death of the former director, Dr. Paul Brehm, last April. He has the degree of Ph.D. in chemistry from the University of Wisconsin and was with the state board of health as an engineer from 1940 to 1948.

SAYS PERMANENT AND TOTAL DISABILITY FEATURE LEADS TO SOCIALIZED HEALTH

Washington, D. C., Feb. 28.—Speaking for the American Medical Association, Dr. Gunnar Gundersen, La Crosse, today opposed extension of the federal social security system to cover permanent and total disability as proposed in H. R. 6000.

Dr. Gundersen, a member of the executive committee of the AMA board of trustees, told the Senate finance committee that the House approved bill to liberalize social security was another step toward socialized medicine.

Two Reasons

"The American Medical Association must oppose H.R. 6000 for several good reasons. First, although the physician has always readily accepted the challenge of treating the ailments of his patients, the provision regarding disability certification in this bill would compromise the physician because it would establish a new, different, and puzzling physician–patient relationship. Second, the disability sections of this bill would most definitely establish a bench–mark for further expansion of these disability provisions towards a full-fledged system of compulsory sickness insurance.

Not Insurance

He warned that there are "serious medical implications" in the proposal to figure disability benefits on the same basis as old age benefits. He pointed out that the AMA recognizes the need for helping the disabled needy, but that this aid should always be locally administered.

He added that the opportunities for malingering would be multiplied many times under the new program, and that the bill would take the social security program out of the insurance category.

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THE PRICE OF HEALTH: TWO WAYS TO PAY IT

(Courtesy of TIME, Copyright Time Inc., 1950)

In the field of medicine, the biggest news of the last two decades has been the discovery of life-saving wonder drugs—the sulfas and antibiotics. But the most heated discussion, among doctors and laymen alike, has been about the cost of medical care.

The problem is greater and more complicated, and goes much deeper, than the emotional, sloganized fight between "free" and "socialized" medicine. It breaks down into two parts: 1) how to help (or force) people who can afford to pay their medical bills to budget or insure these costs; 2) how to improve the overall health of the nation by providing that everybody gets adequate medical care regardless of means.

At the root of the first problem, which is primarily financial, is the basic human frailty expressed in the old saying: "The doctor is always paid last." Put in more modern terms, it was summed up by a prominent California physician: "The average patient isn't for socialized medicine until he gets his bill."

The second problem stems from the comparatively recent notion that a nation which undertakes to guarantee the financial security of its people should also guard and improve the health of every one of its citizens. This problem is political, moral and social as much as financial. Much of the confusion of recent years has resulted from the fact that the two problems have not been kept separate.

Peace and War

As long ago as 1932 the Commitee on the Costs of Medical Care, headed by the late Dr. Ray Lyman Wilbur (then Herbert Hoover's Secretary of the Interior, longtime president of Stanford University), reported after five years of study: "Human life in the U. S. is being wasted as recklessly, as surely, in times of peace as in times of war. Thousands of people are sick and dying daily in this country because the knowledge and facilities that we have are inadequately applied. We must promptly put this knowledge and these facilities to work."

The Wilbur committee urged that the costs of medical care "be placed on a group payment basis, through the use of insurance, through the use of taxation, or . . . both of these methods."

Since that time, the nation's health has vastly improved, for many reasons. Payrolls shrunk by the Depression have swollen in boom times and given millions added buying power for medical care. The wonder drugs have worked miracles. World War II, though it killed and maimed hundreds of thousands, gave millions of men and women better medical and dental care than they had ever had before, and made them health-conscious. Group insurance has enabled many families to go to the doctor oftener—and earlier, when it does the most good.

Plant and People

Today, the U. S. has almost—but not quite—the world's healthiest citizens,* and the world's biggest medical plant: 6,335 hospitals with 1,423,520 beds and 87,596 bassinets. In 1948, a total of 445,478,364 patient-days were spent in them.

From these facilities, many Americans already get free medical care. For the 1,500,000 men in the armed forces and their 1,800,000 dependents, who get virtually all medical and dental care at Government expense, there are 132 hospitals with 55,252 beds, served by 6,755 doctors and 2,083 dentists. Almost 20 million veterans get free medical service in emergencies or for service-connected ailments, can also get free service for other ailments if they swear that they cannot pay for it. For them there are 125 hospitals, 4,211 doctors and 884 dentists. Free care is given to 140,000 Americans in state and federal prisons, and to 335,000 Indians. Some free care is given to hundreds of thousands of employees by far-sighted industrial and commercial concerns.

Across the land are 1,500 city, county and state hospitals, about half of them for chronic illnesses such as insanity and tuberculosis. Almost 700 give a wide and ever-widening range of general medical care without charge to those who cannot pay for it. Countless persons too proud to accept "charity" publicly, go to private physicians but do not pay their bills; they represent 5% of some doctors' practices, up to 25% of others.

The Bureau of the Census lists 202,000 physicians (M.D.s), many of whom are retired, or working for the Government, insurance companies, medical colleges or research groups, leaving an estimated 150,000 in active private practice, general or specialized. There are also 11,233 osteopathic physicians.

Dollars and Drinks

Medical care costs the U. S. consumer $4 out of every $100 that he spends. This added up to a whopping $7.4 billion in 1948. (Doctors complain that the American people spend more on alcohol —$8.8 billion in 1948.)

Poor and middle-income families pay a higher proportion of their incomes than the national average. The last breakdown (1944) by the Bureau of Labor Statistics showed that a family living on $500 to $1,000 a year spent $88 on doctors, dentists, osteopaths, chiropractors, faith healers, hospitals, X rays, drugs (both prescription and proprietary), eyeglasses and appliances. Families earning $2,500 to $3,000 paid an average of $123 a year; those earning $4,000–$5,000 paid $190; and those earning more than $5,000 paid $265. The 1948 total, based on higher costs all around, was estimated by the Federal Security Agency at $160 each for 46 million U. S. families.

There is infinite variety in the way U. S. families pay for medical care. More than half still do as best they can—out of income out of savings, borrowing from personal loan companies. They meet each medical emergency as it arises. Some do so from necessity, some from choice, deliberately gambling that they will be able to take care of themselves.

Insured Millions

Other U. S. families use insurance to spread the costs of medical care over the years. Their number grew slowly in the first years after the Wilbur committee recommended this method. Lately it has mushroomed, until today 40% of

* Healthier, judged by death rates: those of The Netherlands, Denmark, Norway and New Zealand.

the nation is covered in some degree. No less than 61 million Americans (counting subscribers and dependents) have hospital insurance, 43% of them through insurance companies, 57% through the famed Blue Cross voluntary plans.

Among these 61 million are 34 million who have additional protection against part of the costs of surgery while in hospital. Two-thirds of these policies are written by insurance companies, most of the remainder by voluntary plans in Blue Cross's associate organization, Blue Shield, which has grown phenomenally in four years. Among the 34 million, about 13 million have additional coverage for some physicians' bills, usually only while in hospital. Some 3½ million of these, in turn, are insured against most types of medical expense (excluding dentistry, optometry and chronic illnesses like tuberculosis) from the sickbed at home to the operating room. But even under these policies, usually only the first $2 to $4 for each doctor's visit is covered.

How Insurance Works

Here is a specific example of how the combined Blue Cross and Blue Shield plans work. Last October, the wife of a Bronx freight handler, whose income is $2,400 a year, came down with acute appendicitis. The illness marked the first time that the family had had occasion to use its hospital insurance (held since 1943), now combined with a Blue Shield surgical plan, for preminums totaling $64.32 a year. The wife had an appendectomy and, because of complications, stayed in the hospital 24 days. For the first 21 days, Blue Cross allowed $6 a day; beyond that, $3 a day (it would have paid half benefits up to 180 days). The total bill for the hospital, surgery, and in-the-hospital doctors' visits was $676.56. The insurance paid all but $59.03. Of this, $9 was for the last three days in the hospital and $36 for special nurses.

Blue Shield paid the surgeon its fixed allowance of $100 for the appendectomy. The surgeon had contracted, when he signed up with Blue Shield, to give "service benefits" at its fixed rates to families with incomes of less than $2,500 a year. If the freight handler had earned more than $2,500, the surgeon could have charged more than $100, and the freight handler would have had to pay everything over $100.

Two months after their mother's illness, both the freight handler's sons had their tonsils and adenoids out. Blue Cross and Blue Shield between them paid $141.36 for the two operations, and father did not have to lay out a penny.

Turnover

The people who benefit most by Blue Cross and Blue Shield are steady wage-earners not too highly paid to be eligible for service benefits, and working in a plant where group membership is possible. Both Blue Cross and Blue Shield subscribers are concentrated in the cities and metropolitan areas of industrial states. Rhode Island tops the Blue Cross list with 72% of the state's people enrolled, Delaware is next with 55%, and also tops the Blue Shield rolls with 50%. Eight states (Rhode Island among them) have no Blue Shield plan.

Both Blue Cross and Blue Shield have run into a difficulty which is inherent in voluntary plans: they have a high turnover among subscribers. Many who have no serious illness in the family for a year or two ask themselves, "Why should I pay a lot in and get nothing back?" They drop out. Blue Cross turnover has ranged as high as 25% a year. Those who dropped out were, naturally, the healthiest —from an insurance point of view, "the best risks." Those who came in were likely to be poorer risks.

Indictment

Are these plans adequate to meet the nation's needs and desires for health insurance? Granted that they do not fill the bill today, can they be expanded (for they are still growing fast) to do the whole job?

This is the point at which the Fair Deal, following New Deal thought patterns, steps in with a resounding no. President Truman, lumping the financial and social problems together, proclaimed in January 1949: "In a nation as rich as ours, it is a shocking fact that tens of millions lack adequate medical care." Harry Truman's prescription: "We need—and we must have without further delay—a system of prepaid medical insurance . . ." That system, he said, must be national and compulsory, based on a payroll tax.

A year and a half ago, Federal Security Administrator Oscar Ewing backed up his boss with an elaborate report entitled *The Nation's Health*. Ewing declared: "Every year, over 300,000 people die whom we have the knowledge and the skills to save . . . By & large only the well-to-do and to a certain extent, charity patients, get satisfactory medical care."

More specifically, said Ewing: "A scant 20% of our people are able to afford all the medical care they need. About half our families —those with incomes of $3,000 or less—find it hard, if not impossible, to pay for even routine medical care. Another 30% of American families with incomes between $3,000 and $5,000 would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness."

Blueprint

Ewing's complaint was threefold: 1) the nation was not spend-

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ing enough on health; 2) the spending power was not evenly distributed; and 3) because illness strikes without warning, even a thrifty, budget-careful family may have its savings wiped out and be forced into debt by a catastrophic or chronic illness. To allow the nation to spend more on its health, Ewing had detailed blueprints for building more hospitals, boosting the output of doctors, dentists and nurses, and beefing up public health services. Few argued with these aims, though many—especially doctors fearing federal interference with their profession—disagreed over details of their attainment.

But Ewing went farther. "Our goal," said he, "can be no less than the removal of any economic barrier between the individual and his access to whatever health or medical services he needs. Everything else that is done to promote national health will be virtually canceled if millions of the people are barred from health because they are unable to pay for it out of pocket. [We must] provide that all people shall have access to such health and medical services as they require through a system of insurance covering the entire population" (thus trying to resolve both the financial and social problems at one stroke).

The Cost

The only way to reach this goal, said Ewing, is to tax all U. S. payrolls and self-employed persons to the tune of 3% at first, and eventually 4%, on the first $4,800 of income. On a taxable $150 billion (more than the nation's $133 billion payroll but well under its total personal income of $210 billion), Ewing figures this would yield $4.5 billion at first—just what private U. S. citizens now spend on doctors, hospitals and drugs. But with the same amount of money, Ewing planned to give more of this kind of care to more people—85% of the nation.* Since the money could not possibly stretch so far, Ewing also wanted an open-end account to draw from general tax funds. He estimated that he might need, after the first year or so, an extra $2 billion a year.

* Social Security covers 44 million or 29%. It excludes the self-employed, agricultural and casual laborers, domestic workers and employees of Government and nonprofit groups, most of whom would be covered by national health insurance.

A skilled politician with a sensitive ear for wails of states' rights, local autonomy and professional independence, Oscar Ewing had tried to soothe some possible opponents in advance. He urged a decentralized administration, with the Federal Government doing nothing but collecting the compulsory health insurance funds and doling them out to the states. Every state, said he, should have its own authority; each community area (probably a county) should have its own plan, run largely by volunteer committees with one paid executive.

OSCAR EWING

The law which he proposed, said Ewing, should stipulate that every patient have the right to choose his own doctor, and every doctor should have the right to reject any patient. Any doctor would have a free choice—to join the plan or not. Once in, doctors in a community would decide among themselves how they should be paid: on a fee-for-service basis (so much for each call for each patient), or by capitation (so much a year for each patient on a doctor's list) or, in a group practice,† by salary. They might combine two methods or all three.

Who Would Benefit?

Under the Ewing plan, the Bronx freight handler's premiums would be $72 a year at first, rising to $96 after the plan is widened to cover dentistry, eye care and chronic illnesses. But the freight handler would pay only half ($36 to $48) in direct payroll taxes; his employer would pay the rest.

† Relatively new when the Wilbur committee recommended it, group practice helps doctors to give better medical care by bringing several specialists under one roof (cutting their overhead for rent, office help, expensive equipment and laboratory technicians), and helps the patient by giving him automatic access to the group's specialists.

Actually, the Ewing plan would not make much difference to the Blue Cross–Blue Shield subscriber, such as the Bronx freight handler, in terms of dollars. Most directly benefited by it would be millions of Americans who live in areas where no such plan is available, or who do not qualify for membership because they cannot get into a "group membership" plan, or who are not regularly employed, or who simply cannot afford the premiums. For subscribers to the Blue Cross–Blue Shield types of insurance above the income cut-off, the Ewing plan would offer an apparent saving in years of heavy illnesses or operations. But since this income group is the part of U. S. society which pays heavy income taxes, people in this group would make up most of the deficits in even bigger income taxes. The well-to-do, if they chose to continue going to a non- participating doctor, would pay their full bills. In addition, they would be taxed for something they did not use—just like parents who pay school taxes and then send their children to private schools.

Ewing insists, especially since his recent visit to Britain, that his plan is not "socialized medicine." He reserves that term for systems like the British, in which hospitals have been nationalized. His plan would leave them as at present under private or local control. Also, he maintains, "socialized medicine" covers the systems, common in continental Europe, where doctors are employed by the state.

Capacity to Pay

Before they could quarrel with Ewing's prescription for the nation's health, his opponents had to make their own diagnosis of the nation's ills. In general they agreed that many U. S. citizens were not getting the best of medical care, but they argued that it was not because of inability to pay for it. The Brookings Institution, in a report* made at the request of a Senate committee in the 80th Congress, concluded that families with incomes of $2,000 or more (at 1941 price levels) should have no difficulty in paying for medical care

* *The Issue of Compulsory Health Insurance*, by George W. Bachman and Lewis Meriam, 1948.

if they cut down on luxuries (automobiles, liquor, tobacco, recreational) and savings.

Having pared down the problem, the Brookings researchers proceeded to knock down the Ewing solution. Compulsory insurance, they argued, would mean too much governmental regulation and control, which would creep into the relationship between doctor and patient. Furthermore, politics could not be kept out. Worst of all, "the cost of medical care presumably would increase because of a) administrative expenses; b) the tendency of insured persons to make unnecessary and often unreasonable demands upon the medical care services; and c) the tendency of some practitioners and agencies to use the system for their own financial advantage."

Turnabout

Doctors in general agreed with this indictment, but individually did little at first to prosecute their case. This they left to the American Medical Association. Once (during World War I), the A.M.A. had favored compulsory health insurance. But during Dr. Morris Fishbein's long (1924–49) and bellicose editorship of the A.M.A.'s *Journal*, the tune changed. Though Republican Ray Lyman Wilbur was an M.D. and a past president of the A.M.A., his committee's 1932 report was denounced by Fishbein as "socialism and communism." Under Fishbein's leadership, the A.M.A. at first also opposed both hospital insurance and surgical-medical insurance.

"Education Campaign"

By last year, doctors decided that the U. S. public was not judging the A.M.A. on the merits of its case, but was taking sides for or against Fishbein. So the A.M.A. dumped Dr. Fishbein (TIME, June 20) and hired a firm of San Francisco pressagents, Clem Whitaker and his wife Leone Baxter, to run its "National Education Campaign" against the Truman–Ewing program. Doctors have found it an expensive war: Whitaker & Baxter (for a fee of $100,000 a year) are spending $2,000,000 a year to counter the effects of Ewing's tax-supported propaganda. This year, for the first time, the A.M.A. will collect $25 dues from most of its 143,000 members to finance the battle.

The Doctors' Reply

The A.M.A. sees the nation's health program clearly in its separate financial and social components. It charges Oscar Ewing with exaggerating both, and also exaggerating the difficulties of solving them. U. S. medicine, says the A.M.A.'s President-elect Dr. Elmer L. Henderson, is the world's best, and the nation has more doctors in proportion to population than any other (except refugee-filled Israel). The bulk of its citizens, Dr. Henderson argues, have access to adequate medical care and can afford to pay for it. Doctors and hospitals

DR. E. L. HENDERSON

could be better distributed, he concedes, but he argues that "socialized medicine" would promise vast benefits to people in areas where services are simply not available and could not be made available. Worst of all, Dr. Henderson charges, the plan eventually would cost $12 to $15 billion a year.

Voluntary plans, say A.M.A.'s spokesmen, are adequate and can be expanded to embrace 90 million Americans. The rest—roughly two-fifths of the nation—have been described in A.M.A. pronouncements as "medical indigents." For them, says the A.M.A., the state and federal government should pay premiums out of public tax money to private insurance plans which would be largely controlled by doctors.

The A.M.A. has been getting its message across in many ways. Today, patients in doctors' waiting rooms find themselves facing a blown-up reproduction of Sir Luke Fildes' painting, *The Doctor*. Once used to advertise a laxative, it is now captioned *Keep Politics Out of This Picture*. Each month, meetings of many county medical socities hear denunciations of the Ewing plan. The societies have organized speakers' bureaus and they stage exhibits at state and county fairs. In most areas, the battle cry is "socialized medicine."

Middle Way?

In this heated exchange of charges and countercharges, the U. S. public has looked for a middle way. It has looked in vain to independent doctors who dislike both the Ewing plan and the A.M.A.'s tactics. Most of the effort to find a middle way has been in Congress. Alabama's Lister Hill has a bill in the Senate to take care of medical indigents by using state and federal funds to pay their premiums in voluntary plans. Vermont's Republican Ralph Flanders would buy this, but with a neat compromise added: those who could afford to pay should subscribe to a voluntary plan—but on a sliding scale according to income.

Deductible Plan

One promising compromise suggested a "deductible," familiar in automobile insurance. Individuals would pay something toward their medical bills; a payroll tax fund would cover the rest. Illinois' freshman Senator Paul Douglas, who has turned against the Ewing plan, believes that the individual might pay up to $150 a year, and be covered only for "catastrophic illness."

Time the Healer

The problems were so deep, and emotions running so high, that no national health bill was likely to be considered at this session of Congress. Both parties wanted to save the issue for the congressional elections next November. It might well figure in the 1952 presidential election.

This public airing of the issue would be good for the nation's health—and its pocketbook. There was a situation which needed to be remedied. There was no doubt that with its technical and financial resources and social resourcefulness, the U. S. could find a sound remedy. But the hasty enactment of unworkable legislation, creating an unwieldly bureaucracy, was more likely to impair than improve the nation's health. Such a cure would be worse than the disease.

COUNCIL–MEDICAL BOARD MEETING RESULTS IN NEW APPROACH TO LICENSING FOREIGN DOCTORS

Madison, Feb. 18.—The Council of the State Medical Society held its annual meeting in Madison, Feb. 18 with several members of the State Board of Medical Examiners as invited guests.

Primary purpose of the part of the meeting with Board members was to study the state law pertaining to the licensing of physicians educated in foreign schools and to review the various official reports made recently in connection with this matter.

Press Statement

The following press statement was made by the Council after the meeting:

The Council believes that the State Board of Medical Examiners has acted not only in entire good faith in the matter of reviewing qualifications of those educated in foreign countries, but that the Board is to be particularly complimented on the fact that it has been the moving influence bringing about a study which just recently reported evaluation and approval of some 38 foreign schools, with further reports to be made as rapidly as studies can be conducted.

In the face of such a constructive record it is unfair to accuse the Board of trying to build a fence around medical practice in Wisconsin. The Board consists of highly respected individuals, many of whose immediate forebearers come from foreign countries. If they have done any "fence-building," it is that as a state agency, not responsible to any other group but the public through its legislative and judicial processes, it has consistently and properly sought to protect the health of the people of this state.

May Meet in April

There is no valid reason to try to telescope a most important program of foreign medical school evaluation into a matter of a few weeks or months. If the Board of Medical Examiners were to respond to some of those importuning it to act, the Board would be making a mockery of the evaluation study.

The Council anticipates that the State Board of Medical Examiners

DR. R. G. ARVESON

at its next meeting to be held in April will accept the national report on foreign schools and will continue to accept those reports as made.

Will Accept Applications

Members of the State Board present at the meeting stated that the policy of the Board will be to accept for examination graduates of those schools which have received approval of the national accrediting body. In addition, the members of the State Medical Board stated that it will continue in the future to receive applications from graduates of schools not as yet formally qualified and expect the applicant to fulfill his unquestioned legal responsibility of showing evidence that his training was in a reputable medical school, and was equivalent to that required in the medical school of the University of Wisconsin.

SMS Will Help

He should submit more than photo-copies of certificates of graduation. He should submit details as to his premedical training, the course offered by the school, its teachers and their records, and the kind of physical plant.

He should demonstrate that he was trained, in part at least, by methods other than lectures, mimeographed or oral. He should know the laws of this state pertaining to dispensing of dangerous drugs, to the use of narcotics, and those pertaining to public health such as quarantine and the like.

Only then will the Board be in a position to review such material, and to ask national agencies, including the Council on Medical Education of the American Medical Association. The Council of the State Medical Society has instructed its secretary's staff to render such assistance as it may be called upon to perform by the State Board of Examiners.

May Change Laws

The Council has received several suggestions. One is the development of some form of educational license for those desiring residency training and the like. Another is that the State Board of Medical Examiners be given a power it does *not* now possess—that of considering such additional training as an applicant may have acquired since coming to this country. Both suggestions are referred to the Society's Committee on Medical Education for study and report to the House of Delegates in October, 1950.

In the meantime, the Council warns that this problem is nothing with which to trifle. Sound health depends on sound training and knowledge. There will always be exceptions to a rule but that is no argument against the soundness of the rule.

Physicians Invited to Public Health Meeting

Madison, Feb. 3—A movement is under way to organize a Middle-States public health association, representing twelve states in the Wisconsin area with the hope of eventually becoming a branch of the American Public Health Association. Dr. E. H. Jorris, chairman of the board of directors of the Wisconsin Association for Public Health, announced that a special invitation is being extended to all individuals interested in public health work to attend a Middle-States' meeting in Des Moines, Iowa, on May 4–5.

Dr. Jorris urges physicians to attend the first meeting. Specific information may be obtained from Dr. E. H. Jorris, State Board of Health, State Office Building, Madison, Wisconsin.

"WHITEWASH" SAYS MILWAUKEE JOURNAL

"Whitewash for Doctors' Fence"

Feb. 20, Editorial

The State Board of Medical Examiner's 12 year policy of banning all foreign trained doctors from Wisconsin now has the *official blessing* of the State Medical Society Council.

In secret session, the doctors who speak for the profession in Wisconsin have sat in judgment on doctors who *supposedly* represent the public interest in licensing physicians to practice in the state. And the latter doctors have been absolved by the former doctors of following any selfish professional interests in establishing the foreign doctor exclusion policy.

The Medical Society Council has the effrontery to state that the "fence around the medical practice" in Wisconsin has only been erected to "protect the health of the people of this state." The Council could take lessons in forthrightness from James Caesar Petrillo. He and his musicians' union don't make any sanctimonious claim of protecting the culture of the public.

All the sugary words in the world do nothing to erase the facts on the medical exclusion record in Wisconsin. Doctors of unquestioned ability and repute have been arbitrarily barred from examination in Wisconsin by a policy of the Board which was never imposed by the legislature, courts or public. Communities and institutions *in need* of those doctors have been denied them—by the Board and by nobody else.

The Board of Medical Examiners has, under the lash of criticism, taken the initiative in putting a gate in the fence now by which it *may* choose eventually to let in some foreign doctors for examination. But to date the fence is still there. The State Medical Society Council is naive to think that a nice new coat of whitewash is going to make people forget who built the fence—or *why*—and how it has been misused.

The whole business is another reflection of the paternalistic, proprietary attitude on the part of medical profession spokesmen which has hurt the doctors' public relations so much. This is extremely regrettable at a time when the profession needs public support as never before, if it is to head off state medicine.

The State Medical Society Council says, a bit belligerently, that the State Board of Medical Examiners is "not responsible to any group but the public." That *should be* the literal truth. But the Board has not yet held itself responsible to anyone except itself and the profession and selfish professional interests.

The Board's responsibility to the public is apparently only going to take precedence under the strongest public pressure—through the governor's office, the legislature—and courts, if necessary.

C. H. CROWNHART, SECRETARY
THE STATE MEDICAL
704 EAST GORHAM STREET
MADISON 3, WISCONSIN

Mr. John Baker
Milwaukee Journal
333 West State Street
Milwaukee, Wisconsin

Dear Mr. Baker:

I well realize that an editorial constitutes an expression of opinion, and that a reader is confronted with agreement or disagreement with that opinion.

Your editorial of February 20 on the licensing of foreign trained physicians prompts me to call attention to several important facts which you seemingly missed in evaluating the report of the Council on its meeting with some members of the State Board of Medical Examiners.

Fact: Members of the Board represented that they would vote to accept graduates of schools approved by the A.M.A., and the recent report okayed 38 such foreign schools.

Fact: Members of the State Board of Medical Examiners in Wisconsin were a moving factor in initiating the study of foreign schools.

Fact: The Board will meet in April so that there may be no undue delay in handling applications on file from graduates of such schools.

Fact: Studies of foreign schools are not completed. There are approximately 250 schools in other countries. The Department of State has indicated the practical problem of travelling in some countries and its representative on the A.M.A. steering committee has counselled delay.

Fact: Members of the Board present at the meeting said that they would accept applications from graduates of schools not as yet approved. In those cases, the applicant has the burden of proof in demonstrating what the *law* requires him to show:

> That he was trained under the same general conditions as are required of those attending the medical school of the University of Wisconsin.

In obtaining this committment from members of the Board present, the Council certainly was not backing any type of "blanket" exclusion policy.

Fact: The Board would be acting beyond the law if it considered additional training acquired since graduation as bringing up school training to equivalency with that provided in this country. In view of this, the State Medical Society is planning to study means of creating a reasonable law so that the Board can have this authority.

Fact: Residents in hospitals must be licensed. This applies to men from foreign countries as well as our own graduates. The State Medical Society will study the feasibility of an "educational license" for foreign graduates who, in some cases, may find it impossible to obtain a regular license.

I can understand your reaction to the meeting of the Council Feb. 19, but you must also understand that the far-reaching implications of licensing to practice medicine involve a responsibility of grave character. Entrusting the lives of people to a person given the stamp of approval by a Board charged with such responsibility by law is a matter of serious public concern, and should not be treated lightly. I know that your sense of public responsibility is of such a nature that you will wish to present this problem with all facts before you.

I hope that you never see fit to close the eyes of the public to the dangers of indiscriminate licensing, but always do what you can to recognize the broad public health implications in the actions of the Board.

Very sincerely yours,
/s/ C. H. CROWNHART,
Secretary.

AMA Approval Granted Medical Schools in 9 European Nations

Chicago, Feb. 7.—The American Medical Association gave its "approval" to 27 foreign medical schools after its inspection team visited each school and issued a favorable report to the effect that the graduates, past and present, could be considered for licensure on the same basis as graduates of approved American schools.

The Wisconsin State Board of Medical Examiners was one of the primary motivating factors in the study.

Approval Retroactive

In making the announcement, Dr. Donald G. Anderson, secretary of the AMA Council on Medical Education and Hospitals, issued the following statement:

"On the basis of information presently available, the Council on Medical Education and Hospitals of the American Medical Association is of the opinion that medical institutions and medical organizations in the United States would be justified in considering current and past graduates of the following foreign medical schools on the same basis that they consider graduates of approved medical schools in the United States. This list is not final and will be supplemented as information is compiled for other schools."

Denmark

University of Copenhagen Faculty of Medicine

Finland

University of Helsinki Faculty of Medicine

Medical Faculty Turku University

Netherlands

University of Amsterdam Faculty of Medicine

Royal University of Groningen Faculty of Medicine

Royal University of Leiden Faculty of Medicine

Royal University of Utrecht Faculty of Medicine

Norway

University of Oslo Faculty of Medicine

Sweden

Royal Charles University Medical Faculty, Lund

Charles Medico-Surgical Institute, Stockholm

Royal University of Uppsala Medical Faculty

United Kingdom

England

University of Birmingham Faculty of Medicine

University of Bristol Faculty of Medicine

University of Cambridge Faculty of Medicine

University of Durham Medical School, Newcastle-upon-Tyne

University of Leeds Faculty of Medicine

University of Liverpool Faculty of Medicine

University of London**

University of Manchester Faculty of Medicine

University of Oxford Faculty of Medicine

University of Sheffield Faculty of Medicine

Northern Ireland

Queen's University of Belfast Faculty of Medicine

Scotland

University of Aberdeen Faculty of Medicine

University of Edinburgh Faculty of Medicine

University of Glasgow Faculty of Medicine

University of St. Andrews Medical School, St. Andrews and Dundee

Wales

Welsh National School of Medicine, University of Wales, Cardiff

** Work for the medical degree of the University of London is offered at the following hospital medical schools:

Charing Cross Hospital Medical School
Guy's Hospital Medical School
King's College Hospital Medical School
London Hospital Medical School
Middlesex Hospital Medical School
Royal Free Hospital School of Medicine
St. Bartholomew's Hospital Medical College
St. George's Hospital Medical School
St. Mary's Hospital Medical School
St. Thomas' Hospital Medical School
University College Hospital Medical School
Westminster Hospital Medical School

AMA Inspection Team Reports on Medical Education in Europe

Madison, Feb. 10. — Reports on the acceptability of foreign medical schools were presented at the 46th Annual Congress on Medical Education and Licensure held in Chicago on Feb. 6–7.

Individual members of the American Medical Association committee which toured Europe to study the schools reported on the general status of the institutions as it affects the American licensing of physicians trained abroad.

The highlights of the individual reports follow:

Switzerland, Dr. Freddy Homburger, research professor of medicine, Tufts College Medical School:

"Five major medical schools (Basel, Luzerne, Geneva, Zurich and Bern) are venerable institutions . . . it is to their merit that Switzerland has today one of the best trained medical professions in the world . . . schools improved greatly since 1900 . . .

"Performance of those in teaching positions is superior to the average instructor in the average medical school here . . . educational requirements of medical students practically identical with U. S. . . . hospitals and laboratories well equipped . . .

"Problem arises out of two levels of examination . . . stiff federal examinations must be taken by those who wish to practice in Switzerland . . . only Swiss citizens may take it . . . but foreigners in Switzerland or Swiss medical graduates who don't want to practice in Switzerland may take an easier examination . . . Swiss educators are willing to change the regulations to raise all examinations to one, high level . . . will make changes necessary to bring evaluation up to U. S. standards . . . do not wish to serve as back door for unqualified American students to profession of medicine in this country."

Dr. Donald G. Anderson, secretary of the AMA Council on Medical Education and Hospitals reported that it "may be possible" to add Swiss schools to the approved list about June of 1950.

Great Britain, Dr. Harold S. Diehl, dean of medical sciences, University of Minnesota Medical School:

"To be eligible for registry (licensure) in Great Britain one must present a diploma from one of the universities or . . . take the examination of one of the Conjoint Boards . . . which permit a student to take examinations one at a time and if he fails in one, he can repeat that interminably or until he wears himself out . . . the Council recommends that only medical graduates holding degrees from a university in the United Kingdom be justifiably considered for licensure on same basis as graduates from approved medical schools in this country . . . this does not include those holding diplomas of old Conjoint Boards or the Society of Apothecaries . . . nor does it include schools of the Irish Republic where the medical schools accept no direct responsibility for clinical teaching . . . student takes his clinical work in any hospital . . . need show only attendance record . . . majority of British graduates plan to stay in United Kingdom . . . most applicants that we'll get in this country will be from schools in South Ireland where they are graduating about three times as many students as their country can absorb."

Scandinavian Countries, Dr. Creighton Barker, secretary to the Connecticut Medical Examining Board:

"Hardly any physicians from these countries (Denmark, Sweden, Norway and Finland) want to come to this country because they are so happy there . . . so far as I could learn, there are no students from the U. S. in any of those schools . . . English is spoken in the schools . . . many teachers have had training in U. S. . . . many hospitals are something to dream about . . . great cooperation between all four countries in medical education . . . I came back feeling that the schools of these countries were doing a fine job of medical education, that we should be proud to have them in this country, and we should welcome graduates from these schools into our society if they wish to come."

Italy, Dr. Vernon W. Lippard, dean, University of Virginia Department of Medicine:

"All faculties of medicine are in 22 government supported schools . . . although curricula are approximately identical, faculties and facilities vary greatly . . . Germans carried off much equipment that has not been replaced . . . before the war, total enrollment was about 12,500 students . . . in 1947–48 enrollment was 34,963 . . . without any increase in facilities . . . small group instruction abandoned . . . I would hesitate to recommend unqualified endorsement until some method of controlling enrollment is adopted."

South America (including Latin America), Dr. Robert Lambert, staff member of Rockefeller Foundation:

"Conditions in regard to medical education in South America are today comparable to what they were in this country 50 years ago . . . possibly 2 or 3 schools that might meet standards set up by the Council . . . great majority of the 50 medical schools not only would not qualify now, but probably not in the early future."

Suggest Five Ways to License Displaced Physicians Without Lowering Standards

Chicago, Feb. 7. — Regulations covering the licensure of displaced physicians can be modified without lowering the standards, declares Dr. Alexander M. Burgess, Providence, R. I., section chief in medicine for the Veterans Administration in the New England–New York area.

Speaking at the annual Congress on Medical Education and Licensure of the AMA, Dr. Burgess reported that nearly 2,300 physicians registered with the International Refugee Organization of the United Nations and certified for the medical care of their compatriots, remain in Europe at this time.

"The lack of familiarity with customs and usages has led many a foreign physician to make errors in dealing with his patients and his colleagues that have earned him the ill will of his brother practitioners and have given a bad name to refugee doctors generally," he said. "This has been particularly true in the past when the average doctor who escaped to this country was, it appears, not of as high a type as has been coming to us in the last two or three years."

He urged a training period for any physician who has not already studied or at least resided in this country for several months. He pointed to the plan in Iowa where the State Board of Medical Examiners approves the appointment of foreign medical school graduates and displaced physicians as assistant physicians in six state institutions. Their future course is considered after one year.

Dr. Burgess also suggested that:

(1) Certificates of the IRO be accepted as evidence of graduation in medicine;

(2) Restrictions on licensure of European physicians who have graduated in the last 10 years be lifted in the case of those who have received IRO certification;

(3) States in which foreign graduates are "not accepted" — there are 22—revise this restriction to allow practice by displaced physicians;

(4) State medical boards consider possible training facilities for the special purpose of orienting and training foreign physicians for medical practice in the United States.

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Dr. Arveson Announces Council Committees

Madison, March 7 — Forty-eight physicians have been named to ten committees of the state medical society, it was announced today by Dr. R. G. Arveson, Frederic, chairman of the council.

Dr. Arveson named Doctors J. M. Bell, Peshtigo; A. H. Heidner, West Bend and R. E. Galasinski, Milwaukee to the interim committee of the society to serve throughout 1950.

Wisconsin Plan

He named Dr. Robert Krohn, Black River Falls, as chairman of the Wisconsin Plan committee which directs the operation of a society sponsored health insurance program sold through private insurance carriers. Doctors Richard Foregger, Milwaukee; C. G. Reznichek, Madison, and Robert M. Moore, Frederic were also named as new members of the committee. Others reappointed to the committee were Doctors L. A. Copps, Marshfield; G. W. Carlson, Appleton; Charles Fidler, Milwaukee; H. B. Christianson, Superior, and H. E. Kasten, Beloit.

Open Panels

Dr. Arveson also appointed the following committees:

Audit and Budget—Doctors J. M. Bell, Peshtigo; A. J. McCarey, Green Bay; N. J. Wegmann, Milwaukee; J. C. Fox, La Crosse, and E. M. Dessloch, Prairie du Chien.

Open Panels — (Committee to provide employees in Wisconsin with a wide choice of medical care in case of compensable injury or illness)—Doctors R. M. Kurten, Racine; J. P. Malec, Madison, and Millard Tufts, Milwaukee.

Veterans Affairs

Advisory to Department of Veterans Affairs—Doctors B. J. Hughes, Winnebago; S. M. Evans, Milwaukee; A. J. Wiesender, Berlin; W. S. Middleton, Madison; R. W. Blumenthal, Milwaukee, and J. S. Supernaw, Madison.

Advertising — Doctors Harry Beckman, Milwaukee; A. L. Tatum, Madison, and N. A. Hill, Madison.

Venereal Diseases—Doctors Stephan Epstein, Marshfield; J. M. King, Milwaukee; P. C. Gatterdam, La Crosse; O. A. Stiennon, Green Bay, and G. A. Cooper, Madison.

Operating Committee, Veterans Medical Services—Doctors J. S. Supernaw, Madison; W. C. Finn, Fond du Lac; Maurice Hardgrove, Milwaukee; F. D. Weeks, Ashland, and J. L. Moffett, Platteville.

Military Medical Service—Doctors F. L. Weston, Madison; M. J. Musser, Jr., Madison; J. M. Sullivan, Milwaukee; J. S. Wier, Fond du Lac, and A. H. Gundersen, La Crosse.

Group Insurance Study—Doctors Maurice Hardgrove, Milwaukee; T. C. Hemmingsen, Racine; L. H. Lokvam, Kenosha, and G. M. Shinners, Green Bay.

AVERAGE AMERICAN LIVES 67 YEARS

Washington, D. C., Feb. 16—The average length of life in the United States has increased to 67.2 years, according to figures released by the public health service.

CAN YOU USE THESE RECORDINGS?

Recordings of talks on socialized medicine by Dr. Louis H. Bauer, chairman of the AMA board of trustees, and Dr. Ralph J. Gampell, formerly of Manchester, England, are available at the State Medical Society office.

They run 13 minutes and are for use either on radio broadcasts or at meetings.

Dr. Bauer's talks tells what would happen in America if socialized medicine is adopted. Dr. Gampell tells what has happened in England under a national health plan like that proposed in the United States.

If you can use these recordings write RADIO, The State Medical Society of Wisconsin, 704 E. Gorham St., Madison, Wisconsin.

Deaths of Mothers in Childbirth Cut by One-Half in Three Years

Madison, Feb. 20—A mother's chance of dying in childbirth has been more than cut in half in the last three years as a result of the joint efforts of the State Medical Society and the State Board of Health, Dr. Carl N. Neupert, state health officer, reported Sunday (Feb. 19) at a meeting of the Council of the State Medical Society.

Dr. Neupert termed "most remarkable" the reduction of the number of mothers who died in childbirth from 101 in 1946 to an estimated 50 in 1949, even though the number of live births increased by 6,000.

Ten years ago, he said, 159 mothers died in 54,000 live births for a maternal mortality rate of 2.8 per thousand live births. Dr. Neupert estimates only 50 mothers died during 1949 in 80,000 live births for a rate of .06 per thousand.

"More and better prenatal care as the result of doctors' postgraduate training programs of the State Medical Society has contributed greatly to this accomplishment," Dr. Neupert declared. A maternal and child welfare committee, having both medical society and board of health members, has also had "a great effect."

Other factors in the rapid reduction of deaths of mothers are that 96% of the babies were delivered in hospitals and that 99.9% of the women were delivered by practicing physicians. Midwives, neighbors and others accounted for only one-tenth of one percent of the deliveries.

The rapid drop in the maternal death rate can be seen from the following figures presented by Dr. Neupert:

Year	Live Births	Mothers Died	Death Rate
1939	54,000	159	2.8
1946	74,000	101	1.4
1947	83,900	87	1.04
1948	81,300	84	1.04
1949 (est)	80,000	50	.06

Dr. Neupert also revealed that applications have been approved for the construction or addition of 35 hospitals with the help of federal funds. Ten are under actual construction. The program will add 1,269 general hospital beds in Wisconsin by 1953, he said.

The total cost of the 35 hospitals is over $28,000,000, more than $17,000,000 of which is being supplied from local and state sources, the remainder coming from federal funds. The new building is primarily intended to help rural areas.

BLUE CROSS HEAD ATTACKS PRIVATE INSURANCE COMPANY PREPAID PLANS

Milwaukee, Feb. 16—While hailing Blue Cross as the "first line of defense" for the continuation of the free, American way of providing health care, Leon R. Wheeler, Milwaukee, executive secretary of Blue Cross in Wisconsin, charged that commercial insurance plans are unable or unwilling to contribute toward the solution of the social problem of health care for all the people.

He made this charge at a meeting of hospital administrators and directors of the Wisconsin Hospital Association in Milwaukee on February 16.

The stress of present-day hospital economic circumstances has led some Blue Cross plans to "compromise with commercial insurance methods," he claimed. "And some hospitals have been misguided into believing that commercial insurance companies can solve the problems of hospitals as well as the public."

"Unfair" Competition

Acclaiming "community service" —an enterprise including doctors, hospitals and the people—as the greatest single asset of Blue Cross, Wheeler added:

"What commercial insurance plan, no matter how good it is, could have the interest, the faith and the goodwill of the people like Blue Cross has? What commercial insurance plan could make working partners of the people in the neighborhood, the doctor down the street and the hospital up on the hill? And what commercial insurance plan *could* or *would* make progress toward solution of what is our fundamental problem today—the social problem of health care for all the people?"

"Only in a community plan, sponsored by many doctors and many hospitals for many diverse groups of people, can the maximum number of people be enrolled," he claimed.

L. R. WHEELER

Blue Cross must "remain a low-rate plan" if it is to keep up its large membership, Wheeler declared. He warned that Blue Cross rates "will have to rise even more than present costs have forced them" if hospital administrators "draw more heavily on Blue Cross funds than is warranted."

Wheeler charged "unfair competition" because "commercial insurance company hospital benefits have not kept pace with increased hospital costs." This, he claimed, permits commercial companies to sell a lower rate plan than Blue Cross.

Editor's Note: In *ten* years, Blue Cross has attained an enrollment of 750,000 persons. The *Wisconsin Plan*, a hospital-surgical plan approved by the State Medical Society, but sold by "commercial insurance companies," has enrolled 225,000 persons in *three* years and has 2,100 participating physicians.

Warn of Hotel Shortage for 'Frisco AMA Meeting

Chicago, March 6—The Palace Hotel has been selected as the meeting place of the American Medical Association's House of Delegates at the San Francisco session, June 26-30. Delegates and officers will be housed at the Palace Hotel, but because it has been impossible to secure enough rooms there, officers of some of the sections will be staying in other hotels.

All others who plan to attend the session are requested to contact Dr. William H. Rustad, Chairman of the Subcommittee on Hotels of the local Committee on Arrangements, Room 200, 61 Grove Street, San Francisco 2, California.

Beckman and Tatum Aid Pharmacopoeia Revision

Madison, Mar. 11.—Drs. Harry Beckman, Milwaukee, and A. L. Tatum, Madison, editors of the Comments on Treatment page of the *Wisconsin Medical Journal*, have been named official members of the United States Pharmacopoeial Convention.

The Convention meets in Washington, D. C., May 9–10. Revision of the United States Pharmacopeia is the major item of business. Representatives of medical, drug and other scientific bodies, both federal and private, will meet to conduct the revision.

Society Plans Study of Medical Enrollment

Madison, March 1—A thorough study of enrollment at the University of Wisconsin medical school will be started soon by a committee of the state medical society.

Dr. R. G. Arveson, Frederic, chairman of the council (board of directors) of the society, today revealed plans for the survey in a letter to Dr. J. K. Trumbo, Wausau, chairman of the committee on medical education and hospitals. The study is to be completed in time for the society's annual meeting in October.

To Study Charges

"Not infrequently during the past several years we have heard the claim that medical school enrollment is being limited by unrealistic policies advocated by the medical profession in order to hold down the number of physicians entering practice," Dr. Arveson wrote.

He indicated that these charges were an indictment of the medical profession which should be met with a thoroughgoing study of the matter for the benefit of the profession and the public alike.

Deans on Committee

Both Dr. W. S. Middleton, Madison, dean of the University of Wisconsin medical school and Dr. J. S. Hirschboeck, Milwaukee, dean of Marquette University school of medicine, are ex officio members of the society's committee. Other members are Dr. T. L. Squier, Milwaukee and Dr. P. A. Midelfart, Eau Claire.

FINCH GUEST HOME OPENS IN NEENAH

Neenah, Feb. 24—A 22-bed home for convalescents, the chronically ill and those requiring geriatric care has been opened in Neenah, by Mrs. Berd D. Finch, R. N., veteran nurse and superintendent of the Berlin Memorial Hospital for 14 years. It is known as the Finch Guest Home.

Neenah physicians and citizens report that the home is "something over and above the average old folks home." The Finch Guest home occupies an old mansion near Lake Winnebago. Many of the rooms have been reconverted into private accommodations, equipped with baths, for those who care for themselves. Guests also have the use of a large solarium, library and lounge.

Rapids Druggist Sponsors Socialized Medicine Talks

Wisconsin Rapids, Feb. 1—A complete recording of an address by Dr. Ralph J. Gampell, British physician who turned down the Utopian idea of British socialized medicine, is being broadcast throughout the central Wisconsin area as a result of the efforts of Mr. Paul Reisbeck, owner of a Wisconsin Rapids pharmacy. The transcription is available to other organizations or radio stations wishing to use it.

The entire one hour speech was broadcast over radio station WFHR in Wisconsin Rapids. Mr. Reisbeck also sponsors a program entitled "This is Your Doctor" on the same station.

WOMANS' AUXILIARY GETS NEW BULLETIN

Madison, Mar. 10.—The first issue of a new quarterly bulletin for members of the Woman's Auxiliary to the State Medical Society is expected to be sent to doctors' wives within a month.

The new bulletin, which replaces the Auxiliary page in the Wisconsin Medical Journal, will consist of four pages of news and information on programs, projects, economic medicine, personals, and general information about the "who, what, when, where and why" of medical auxiliary affairs.

Public Ignorance Holds Up Health Progress

Madison, Feb. 23—The fact that public ignorance is holding up health progress in Wisconsin was revealed in a survey recently conducted by the Wisconsin Public Health Council.

Results of this survey were reported at a meeting of the executive committee of the council at the office of the state medical society on February 23.

Want Health Information

Miss Gertrude Clouse, council secretary, told the executive committee that 18 of 27 member organizations surveyed reported a great need for publications, exhibits, speakers and films in the field of health education to help them interest their members in vital public health matters.

Present at the meeting were R. W. Bardwell, Madison, council president; Mrs. Otto Falk, Wauwatosa; Mrs. Paul Phillips, Middleton; Palmer Daugs, Lake Mills; Mrs. Donald Shepard, Neenah; Miss Susan Norman, Waukesha; Harold Link, Kaukauna; Robert Schacht, Madison; Dr. E. H. Jorris, Madison, and C. H. Crownhart, Madison, secretary of the state medical society.

Urge Still Lower Maternal Death Rate

Milwaukee, Mar. 2.—The dramatic reduction in the number of deaths among mothers in childbirth (maternal mortality) in the past three years is good, but not good enough.

That was the consensus of the State Medical Society's committee on maternal and child welfare at a meeting in Milwaukee, March 2. To lower the maternal mortality rate still more they suggested at least one hospital staff conference per year devoted to infant and maternal mortality and morbidity; still better, a staff conference after each infant or maternal death.

Dr. L. M. Simonson, Sheboygan, is chairman of the committee. Other members present at the meeting were Drs. R. F. Purtell, Milwaukee; Amy Louise Hunter and J. W. Harris, Madison, and Mildred Stone, Berlin.

By Joseph S. Lawrence, M.D.
AMA Washington Office

Britain's recent election produces the following reactions:

1. The "welfare state" was not an issue; the issue was whether the "welfare state" should operate with or without government ownership of industries. Narrow victory indicates British people don't want any more nationalization right away.

2. Socialized medicine was never an issue in the election. Labor plans no drastic changes in the program.

3. The "go slow" sign hung up by British voters is legible to American lawmakers. It should slow up expansion of federal powers and controls in U. S.

* * *

A Senate-House subcommittee making recommendations for raising the living standards of low-income families didn't mention Truman's compulsory plan, but urged a program based on "voluntary cooperation of public and private agencies, which will permit all persons who so desire to participate in a system of health insurance."

* * *

American Legion National Commander George N. Craig on Jan. 27 urged establishment of an Armed Forces school of medicine to train men from the military services for military medical careers to stop competition between defense department and private medical needs.

* * *

The legislative committee of the AMA recommended opposition to a bill by Rep. Alvin E. O'Konski, Mercer, Wisconsin, (HR 6982) that would authorize federal grants and loans to cooperatives and nonprofit associations operating medical and hospital care plans for the acquisition, construction and equipment of needed facilities. It said such a plan would lead directly to federal control and socialization of medical care.

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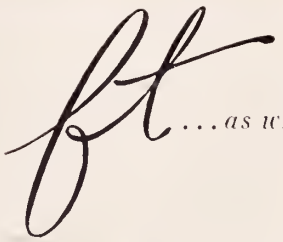

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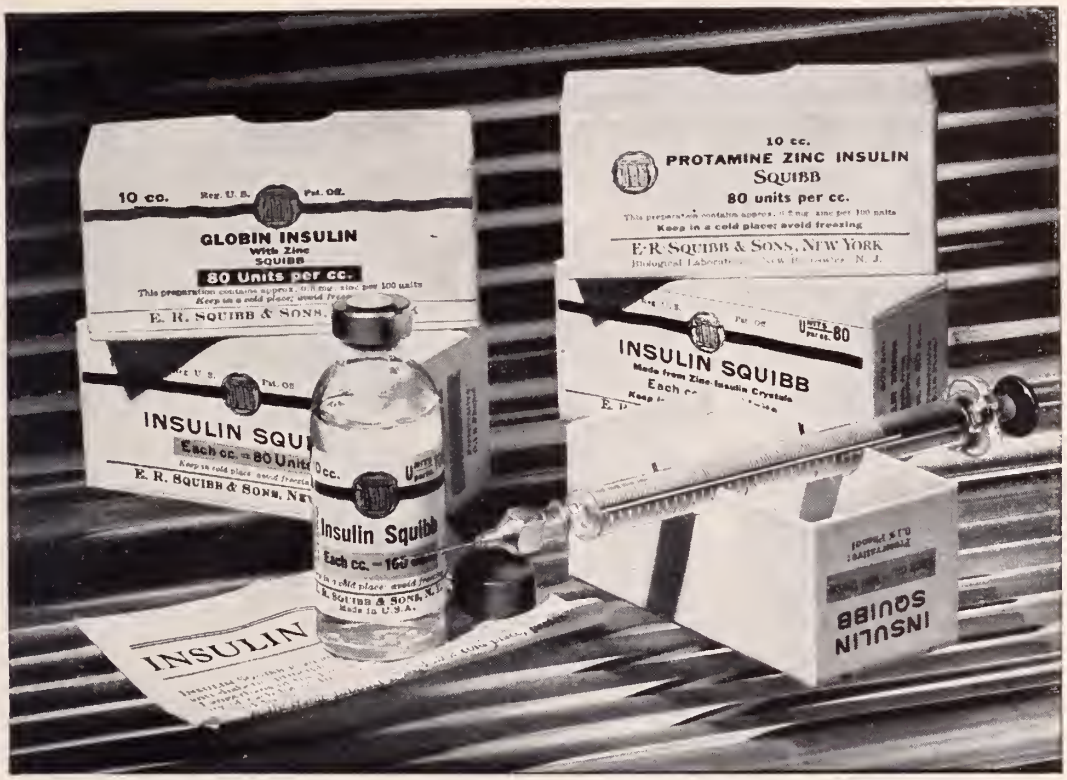

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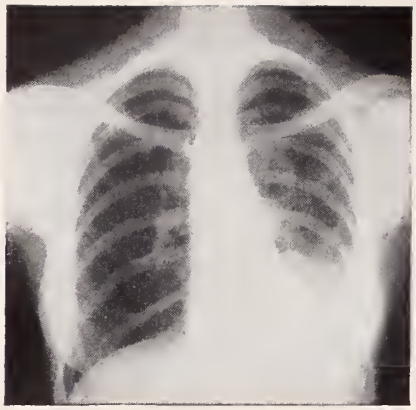

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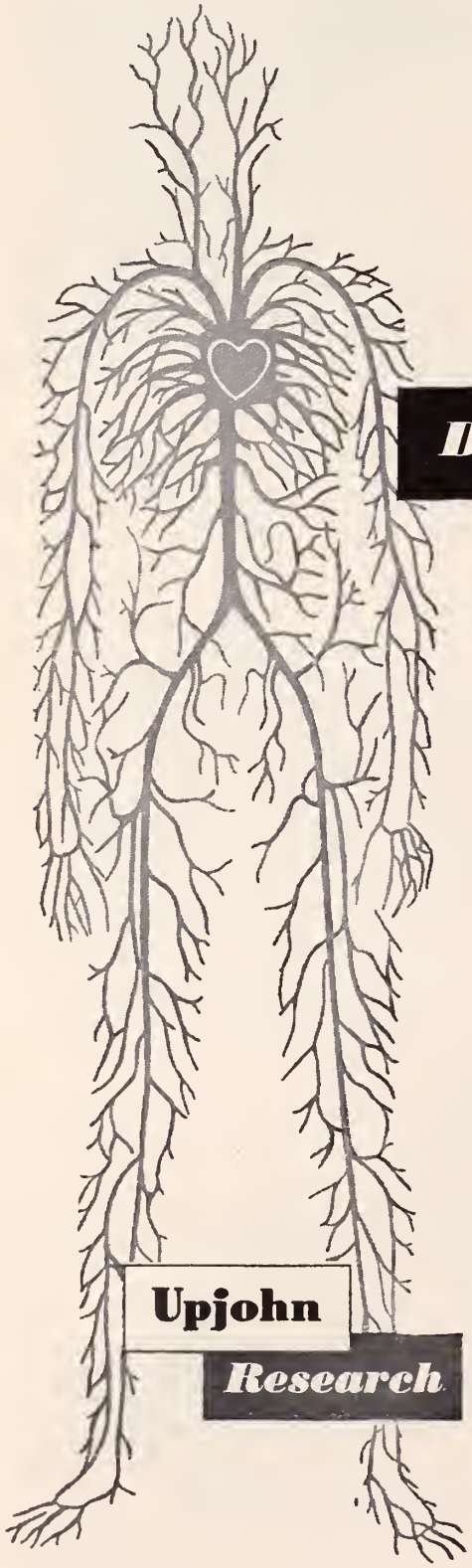

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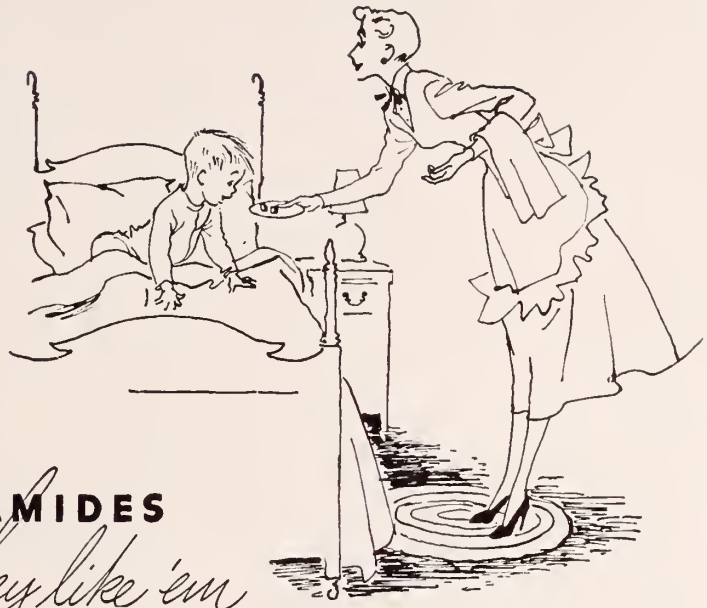

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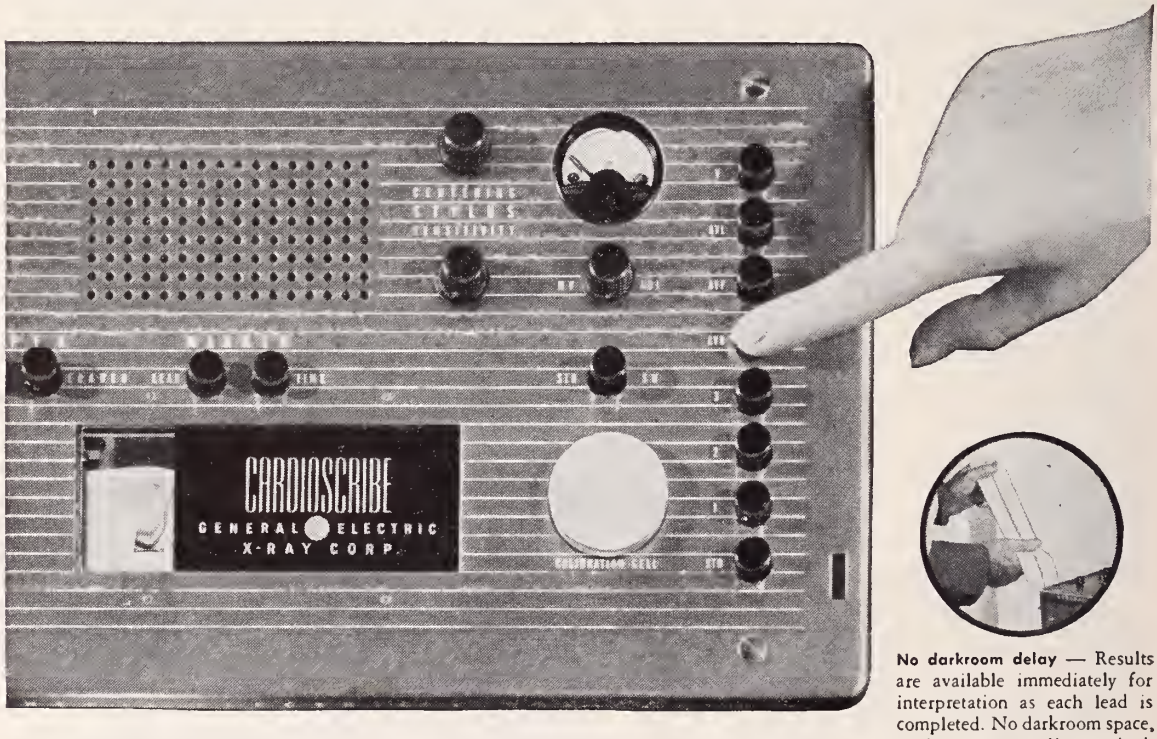

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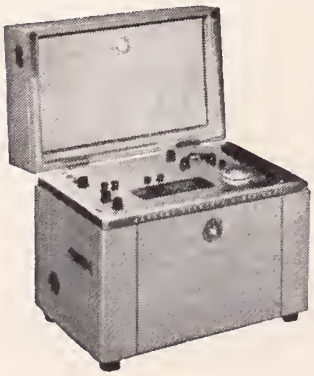

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« « « EDITORIALS » » »

Toward Effective Cancer Control

Since this month is the one in which the American Cancer Society makes its appeal for funds with which to carry on its various programs aimed at the control of cancer, and since the State Medical Society has for so many years been active with a similar program of its own and also has participated with the American Cancer Society in its programs, it seems likely that all members of the Society will be interested in excerpts from a bulletin from the American Cancer Society which recently came to our desk. It is of particular interest to know that research into the causes and nature of cancer is receiving a substantial assistance from the money raised by the American Cancer Society. Dr. Charles Cameron is the medical and scientific director of the American Cancer Society and has written the bulletin from which the following paragraphs are quotations.

The control of cancer eventually will come through an understanding of cancer's causes, means of prevention and effective treatment methods; this knowledge waits on research. The Society has recognized the importance of intensified investigative efforts in the field of growth and spends 25 per cent of its income in the support of such studies and in the training of young scientists to carry them forward. During the present year this support amounts to $3,500,000. The total research expenditure for the past five years is $13,153,560.

April is the month when the American Cancer Society makes its annual appeal to the public for support of its programs. As more and more of our people live longer, the incidence of cancer increases. As the problem becomes more widespread, so must the effort to control the disease be intensified. The Society is dedicated to the principle that through education an effective measure of cancer control may be achieved at this time.

Improved services to patients with cancer are provided by support of cancer clinics, organized pro-

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grams of cancer detection and information services; these efforts are augmented by a corps of volunteers who provide loan closets, transportation services, recreational activities and dressings.

Of immediate interest to doctors is the professional education program. During the past year, three monographs of a series dealing with cancer by anatomic site have been distributed to practicing physicians throughout the country. The series will be continued this year, with distribution at three month intervals.

The professional journal *Cancer*, which first appeared in May 1948, has been well received by clinicians and investigators interested in the problems of abnormal growth. A series of motion pictures for professional audiences, treating the problems of early diagnosis of cancer by anatomic site, has been outlined. Two of the films have been released, the first concerned with the general problem of the early diagnosis of cancer and the second concerned specifically with the early diagnosis of cancer of the breast. A third, covering cancer of the gastrointestinal tract, is in preparation and will be released this year.

A new publication of the Society will appear this year and will be distributed bi-monthly to practicing physicians throughout the country. Topics of interest to the general practitioner will be presented in digest form, together with brief abstracts of significant papers appearing in the literature. Clarity, brevity and general interest will be stressed. It is the Society's hope that this digest will be accepted by the busy physician for whom it is planned.

The library of the Society publishes monthly a bibliography of the current cancer literature which is available on request to physicians, research workers and libraries. The library will prepare, on request, bibliographies on any topic related to the field of cancer. A package lending library has been established which will supply reprints, on a loan basis, to any physician or investigator requesting the service.

The General Practitioner—Why and How

Why are fewer graduates of our medical schools becoming general practitioners? Why is there what appears to be a marked lack of interest in the most challenging field of medicine? Why is there such disinterest in the one medical career that offers the physician an opportunity such as comes to few men, to assume roles of high public esteem while rendering devoted service to man and medicine?

Some who have attempted to answer these questions contend that the medical student has been exposed to so many specialists during his undergraduate and intern days, that he has developed "specialitis." As a remedy it has been suggested that more general practitioners be added to the teaching staffs of our medical schools to "neutralize" the preponderance of specialty men. Several schools are testing the plan, but to date very few have well integrated departments of general practice.

Others have hoped to find the answer by establishing selective general practice residencies in hospitals so that the doctor will become better trained and more capable of handling the myriad of diseases and conditions he is called upon to treat. Hospitals pioneering in this movement warrant the continued and grateful thanks of the profession. Their overtures to the family doctor will help considerably in stimulating medical students to become general practitioners.

While there are many social and economic reasons that medical graduates by-pass general practice, almost everyone neglects to mention one of the fundamental considerations of the young man entering practice—his relationship with a hospital as it affects his ability to practice good medicine and to keep his patients. The time has come for an airing.

When all hospitals welcome the general practitioner as a member of the staff with hospital privileges based on his competence to perform procedures indicated by his experience and training, only then will the intern accept the opportunities and advantages of serving the public as a family doctor. There should be no limitations placed on the work he can do within the scope of his qualifications and ability. He should be allowed a representative voice in the affairs of the professional staff. His application for privileges in a specialty section should be judged on individual merit rather than on requirements duplicating those of specialty boards.

Sir William Osler went to the heart of the problem when he wrote "A well trained sensible family doctor is one of the most valuable assets in a community." Let us be truthful. An intelligent readjustment of the general practitioner's place in the hospital will do much to remove the current apathy toward general practice among young medical men. It may mean more family doctors for Wisconsin communities.—Donald C. Ausman, M.D.

Psychologic Evaluation of Surgical Patients*

A Correlation between Preoperative Psychometric Studies and Recovery

By ROBERT A. SCHNEIDER, M. D., JEROME S. GRAY, M. A., and CHARLES U. CULMER, M. D., Ph.D.

Minneapolis

IT HAS long been known that patients equally ill organically from the same disease react differently. Likewise, patients with the same pathology and subjected to the same surgical procedures vary in the speed and completeness with which they recover. Much of this variation has been attributed to psychosomatic characteristics of the patient. This study was undertaken to investigate some of the psychologic factors pertaining to recovery. An attempt was also made to discover which factors could be so measured and grouped on a scale as to afford a useful preoperative prediction of an individual patient's likelihood of making a good or poor recovery provided, of course, that serious organic complications did not ensue. Such a test would be of great advantage to a surgeon in selecting patients for operation, enabling him with greater accuracy to avoid, or better cope with, that percentage of candidates for elective operation who will be a continuing source of dissatisfaction to the surgeon, themselves, and their families later because they just do not get well.

The family doctor usually knows much about his patient, the patient's family, and his patient's adjustment to life in general. He can estimate quite accurately how his patient will do, from what he already knows about him. A busy surgeon, most of whose patients have been referred to him, seldom has a similar opportunity for insight into the psychologic factors determining the general recovery of an individual patient. For him, especially, any simple test which would yield pertinent insight into the patient's personality, would be a boon in selecting patients for elective surgical procedures.

What is meant by recovery? Ruesch[1] has defined it as follows: "For acute disease the criterion of recovery may be described as the level of psychophysiological functioning which prevailed before the onset of the disease. However, this criterion is not adequate for chronic cases, because many morbid conditions may last a lifetime. In these cases complete recovery is never achieved; nevertheless, the majority of individuals afflicted reach a state of equilibrium, in which they live happily for many years, in spite of their disability." Of patients suffering from acute and chronic illness, a minority never do make an adequate adjustment. It is this group which one would like to detect ahead of time in selecting patients for surgical treatment.

Although many physicians, specialists and others have with fair justification long blamed certain of their failures on the psychosomatic character of their patients, relatively little scientific work has been reported in the literature concerning the psychologic aspects of recovery following illness. So far as we have been able to find, the only important work on this subject is a monograph published in 1946 by Jurgen Ruesch, entitled "Chronic Disease and Psychological Invalidism."

Procedure

A number of possible means of investigation were available. Patients whose failure to recover satisfactorily had already been demonstrated could have been studied in an attempt to find out why they had failed. This had the disadvantage, however, of working only with a poor group and of being open to the criticism that the patients were no longer the same as before operation. While its results might be useful in explaining failures, they probably would have little value in prediction.

A small number of patients could have been interviewed intensively before surgical treatment. However, it would have been very time consuming and probably would not have yielded sufficiently adequate numbers of patients to result in valid samplings. Likewise it could hardly be hoped to produce methods useful to one not a trained psychologist.

A much more objective study of as large a number of patients as possible was elected as most likely to be productive of results on a good cross-section of patients and perhaps of development of a testing technic which could be administered by persons not specially trained in psychology.

During a period of slightly over five months, all patients, both private and non-private, admitted to the University of Minnesota Hospitals on any of the general surgery services were subjected to a standardized set of psychometric studies. There were some exceptions to this. Those patients were missed (1) who came in as emergency cases, (2) who went to operation before the tests could be done, (3) who were incapable of taking the tests because of some organic handicap or illiteracy, and (4) 1 patient who declined to have anything to do with the study. On the whole, very little resistance to taking the tests was met in the course of this investigation. Most of the patients regarded it as part of the general preoperative preparation. The fact that this was done at the University Hospitals perhaps aided in this acceptance. A few were hesitant, but completed the test willingly enough after a brief explanation was

*Read before the One Hundred Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

TABLE 1.— *Preoperative Data Sheet*

Date _____

1. Name _____
2. Hospital No. _____ Age _____
3. Marital Status _____
4. Home Town Address _____
5. Next of Kin to Contact _____ (Name) _____ (Relation)
   _____ (Address)
6. Birthplace _____ Nationality _____
7. Number of Children _____
8. Religion _____
9. Occupation _____
10. Financial Level ( ) Private ( ) Per Diem ( ) County
11. Educational Level (Age in grade) _____
12. Father born in this country? Yes No If not, where was he born _____
13. Mother born in this country? Yes No If not, where was she born _____
14. Number of siblings _____
15. Clinical Diagnosis _____
16. Surgical Procedure _____
17. Duration of Present Illness _____
18. Reason for Surgery _____
19. Previous Operations _____
20. Patient's Adjustment in Hospital
    Ambulation _____
    Cooperation _____
    Emotional _____

TABLE 2.—*Representative Page from Schneider-Gray Inventory*

10.	I notice trouble in swallowing	Very often	Frequently	Occasionally	Rarely	Never
11.	I have had operations before	None	1	2	3	More than 3
12.	The other operations I have had helped me	Very much	Quite a lot	As much as they help most people	Very little	Not at all
13.	I was able to go back to my regular work after the other operations	Very slowly	Slower than most people	Same as most people	Quicker than most people	Very Quickly
14.	I know what will be done to me at my operation	Exactly	Good idea	Some idea	Slight idea	No idea
15.	Most probably I will be in the hospital	2 months or more	4 weeks	2 weeks	1 week	4 days or less
16.	I have had a lot of aches and pains besides those that made it necessary for me to have this operation	A great number	More than most people	Average number	Less than most people	No others
17.	I am fearful of operations	Not at all	Less than most	As much as most people	Very much	Terribly
18.	Hospitals depress me	Not at all	A little	Somewhat	Much	Very much

given. On the average, the tests required approximately two and one-half hours for completion.

The preoperative study consisted of three parts: (1) preparation of a preoperative data sheet (table 1), covering such items as name, age, sex, economic status, previous operations, and so forth, during an interview with the patient; (2) completion of the Minnesota Multiphasic Personality Inventory;[2] and (3) completion of the Schneider-Gray Inventory.

The Minnesota Multiphasic Personality Inventory, hereafter referred to as the MMPI, is composed of 550 statements which the patient answers as "true," "false," or "cannot say." It is given either in a folder form or as a group of cards which the patient arranges into the three groupings. These statements cover many aspects of behavior. The MMPI has been validated extensively both on psychiatric and nonpsychiatric groups.

The Schneider-Gray Inventory, hereafter referred to as the SGI, is a questionnaire containing fifty-seven items developed by Schneider and Gray for use in this study. The items were designed with the intent of eliciting the patient's attitudes toward physicians, hospitals, surgical operations, and certain somatic complaints. Others were devised to bring out more general feelings and attitudes of the patient. The items were scored by the patient along a continuum of a five-step graphic rating scale. Some of the items were original on the part of the designers, others were suggested by items on other personality inventories. Table 2 presents a representative page from the SGI.

Not all of the patients on whom preoperative psychometric studies were made had been operated upon before this investigation was closed for analysis of the data. Deferments of surgical procedures occurred for a number of reasons. However, surgical treatment had been performed on 228 patients at the time the study was closed. On these patients, two forms of postoperative evaluation were undertaken: (1) an estimate of the patient's progress by his attending surgeon (table 3) each time the patient returned to the clinic for routine follow-up; and (2) later a questionnaire was mailed to the patient's nearest relative or friend who was asked to supply certain information (table 4). These latter data were (1) the date of the patient's arrival back home; (2) whether the patient was getting along "very well," "about average," "poorly," or "very slowly," and (3) whether the patient was working as hard as before, "full time," "part time," "not working," or "sick in bed."

There was developed, then, a series of patients on whom (1) preoperative psychometric studies were made, (2) one or more operative procedures were performed, (3) postoperative evaluation of progress was made by the attending surgeons, and (4) an evaluation of recovery was made by the patient's family.

Results and Discussion

During the period when the preoperative psychometric studies were being made, something over 500 patients were admitted to the hospital on a general surgery service. Of these, we succeeded in testing 275 before they went to operation. In economic status these patients ranged from private to free. Their ages ranged from 15 to 82 years. Sex distribution was about equal. The proved diagnoses on the patients used in this study included forty malignancies of all types with and without metastases, ten benign neoplasms, twenty-seven "peptic" ulcers of which seventeen were duodenal, eleven cases of cholecystitis with cholelithiasis, four cases of ulcerative colitis, four inguinal hernias, and thirty-one miscellaneous conditions ranging from patent ductus arteriosus and hyperthyroidism to abscesses requiring drainage.

An average period of five months had elapsed since operation at the time the series was closed for analysis. Of the 275 patients studied preoperatively, 228 had been operated upon within that period.

TABLE 3.—*Evaluation by Attending Surgeon*

Date_____

Patient's Name_____ Hospital Number_____

This is part of a study conducted jointly by the Departments of Surgery and Psychiatry.

It is requested that the member of the surgical staff seeing this patient supply the information indicated below even though he may have previously done so for the same patient.

1. Considering both the organic and functional factors, this patient is progressing—(circle one)
   a. very well b. about average c. poorly d. very slowly

2. Complications:

_____

_____

_____

_____

_____

3. If this patient's postoperative progress is considered to be slower than average (c or d above), estimate the percentage due to organic factors by circling **one** of the percentage figures listed below:

   0 10 20 30 40 50 60 70 80 90 100

Signed_____, M.D.

TABLE 4.—*Data on Recovery Supplied by Family*

Patient's Name_____

Hospital No._____

Date_____
(fill in)

1. When did the patient return home? Date_____
(fill in)

2. The patient is getting along (circle one below):
A. Very well. B. About average. C. Poorly. D. Very slowly.

3. The patient is working (circle one below):
A. Working as hard as before, full time. B. Part time work. C. Not working. D. Sick in bed.

Signed_____

Eleven patients expired in the hospital or shortly after leaving which reduced the number to 217. Query by mail as to recovery result was made of the relatives of these 217; 188 had responded by the time the analysis was started. This number of patients was further reduced to 153 through subsequent discovery of incompleteness of the MMPI or some other insufficiency in the data.

It had been intended to use the evaluation of progress on each patient made by his attending surgeons as one of the criteria of recovery. It was found, however, that except in the case of the "peptic" ulcer patients who were personally followed by one of the authors (C.U.C.), the subjective standards of "recovery" varied too greatly from surgeon to surgeon to be usable or were not attempted at all. So, for the present at least, this step in the experiment was abandoned. "Recovery" criteria, then, depended entirely on the family's report (*vide infra*).

For the 153 patients remaining in the study, the MMPI profiles were checked according to their validity scales, and 34 patients were eliminated because of invalidity on the "L" score ("T" score more than 70) and the "F" score ("T" score more than 80). One hundred nineteen patients comprised the final group used in analysis of the data. These patients all fulfilled the following requirements: they had valid MMPI profiles, they has completed the SGI, and their relatives had submitted an adequate response as to their recovery.

These 119 patients were divided into a good and a poor recovery group on the basis of the family's evaluation in the following manner: Classified as good recovery results were those reported to be (1) working as hard as before, full time; or (2) getting along very well or about average while working part time or not working. In the poor recovery group were placed those reported as (1) sick in bed; or (2) getting along poorly or very slowly although working part time, or not working. The good recovery group contained 93 patients and the poor group 26.

The two recovery groups, good and poor, were contrasted as to age, sex, number of children, birthplace, financial status, occupational level, education, duration of illness, and number of siblings. No statistically significant differences were found. However, a difference was noted when the two groups were compared on the basis of previous surgical procedures. Thirty per cent of the poor recovery group had had four or more previous surgical procedures, compared with 5 per cent of the good group (table 5). Fifty-four per cent of the good patients and 27 per cent of the poor patients had had one or two previous operations. These figures are significant statistically ($p=.0003$). This, of course, is well known to the medical profession.

TABLE 5.—*Correlation of Number of Previous Operations with Recovery Result*

	Number of Previous Operations				
	0	1 or 2	3	4 or more	
Per cent of patients with good recovery	30	54	11	5	100%
Per cent of patients with poor recovery	30	27	13	30	100%

Six classifications of the MMPI profiles were developed by Ruesch:[3] "normal," "mild neurotic," "severe neurotic," "psychopathic," "undifferentiated abnormal," and "psychotic." When the MMPI's of our 119 patients were sorted in this way, a greater percentage of the patients in the good group fell into the "normal" classification and a greater percentage of the poor group fell into the "severe neurotic" classification. The differences are not statistically significant, however.

A scrutinization of the individual scales of the MMPI'S failed to reveal any one scale which distinguished the good from the poor patients. For example, the "D" did not show any greater depression among the poor group. However, there are 550 different statements in the MMPI. It is quite possible that a detailed analysis of each of the items, and its various possible combinations with other items, may later reveal significant correlations with recovery. Such an analysis, which involves a huge amount of statistical labor, is still in process on this series of patients by one of the authors (J.S.G.)

Using those items of the SGI which showed statistically significant differences in distribution according to Chi square, an attempt was made to

TABLE 6.—*Correlation of Schneider-Gray Inventory Scores with Recovery Results*

SGI Scores	23	24	25	26	27	28	29	30	31	32	33	34	35	Total
Number of Cases Good Recovery Group	0	1	0	4	10	13	16	14	11	9	8	3	4	93
Number of Cases Poor Recovery Group	3	3	5	7	4	2	0	1	1	0	0	0	0	26

differentiate the good and poor groups. A scale of ten of the items was used with a cutting score. It showed significant differnces between the two groups but was of no practical use in the individual case.

The final SGI scale, as developed at this time makes use of the "K" score[4] on the MMPI. The "K" score measures test-taking attitudes of the patient. A high "K" score indicates, in general, defensiveness on the part of the patient, reluctance to admit bad things about himself. A low "K" score, on the other hand, connotes a patient open and frank about himself to the point of willingness to put himself in a bad light.

Dividing the "K" scores on the MMPI's at a "T" score level of 60 (one standard deviation above the mean of the general population), the good group of patients were divided into a high "K" group and a low "K" group. The same was done for the poor group of patients. This resulted in four groups: high and low "K" good and high and low "K" poor.

High "K" good and poor cases were mutually contrasted and a scale of significant items on the SGI determined. The same was done for the low "K" good and poor groups. The final number of items chosen on the SGI was fourteen. Of these, five were scored in the reverse direction depending on whether the MMPI "K" score was high or low. The other nine items were scored in the same direction. For each of the fourteen items a score of "1" was in the poor direction, a score of "3" was in the good direction, and a score of "2" was assigned to those responses equivocal in nature. Scores on the fourteen item scale, then, ran from 23 through 35.

The final method of scaling the SGI data, interpreted in the light of the MMPI "K" score, was applied individually to the 119 patients. Of these, 93 had been evaluated by the family as having good recovery results and 26 poor. When cutting scores were used, differentiation between the good and poor patients was highly significant. The scores were grouped from 23 through 26, 27 through 28, and 29 through 35. It is seen (table 6) that most of the poor cases fall in the 23–26 group and most of the good cases in the 29–35 group. Expressed in percentages, 69 per cent of the poor cases fall in the low score group but only 5 per cent of the good cases lie there. In the middle, equivocal, range are 25 per cent of the good cases and 23 per cent of the poor ones. In the high score group are 70 per cent of the good cases and only 8 per cent of the poor ones. Expressed in probabilities, a patient with a low score has only one chance in fifteen making a good recovery. A patient with a high score has nine chances out of ten of making a good recovery. A patient scoring in the middle range has a fifty-fifty chance of being either good or poor.

Scores	23–26	27–28	29–35	Total
Number of Cases Good Recovery Group	5	23	65	93
Number of Cases Poor Recovery Group	18	6	2	26
Scores	23–26	27–28	29–35	Total
Per cent Cases of Good Recovery Group	5%	25%	70%	100%
Per cent Cases of Poor Recovery Group	69%	23%	8%	100%

Illustrative Case Summaries

A patient whose psychometric tests predicted a good recovery.

H. S., a 54 year old farmer of German extraction, entered the hospital as a private patient on Feb. 17, 1948. His chief complaints were epigastric distress and loss of 15 pounds in three months. One year previously, hematemesis and melena had led to a roentgen diagnosis of gastric ulcer. He had had no previous surgical treatment. New x-rays revealed an ulcerating lesion on the lesser curvature of the stomach, which was interpreted as probably carcinoma. Psychometric studies were made on his third hospital day. He had a high MMPI "K" score of 75. A score of 33 on the fourteen significant SGI items placed him in the good recovery-predicted group. On his fourth hospital day a 90 per cent gastric resection was performed. Microscopic diagnosis was adenocarcinoma with positive nodes. He was discharged from the hospital on his seventh postoperative day, experiencing a smooth convalescence. Seven months later, replying to the family's questionnaires, his wife reported that he was getting along very well and working part time. This placed him in the good recovery group.

A patient whose psychometric tests predicted an equivocal recovery.

A. D., a 43 year old white married woman, an American making her home abroad, was brought to the hospital as a private patient on Feb. 4, 1948. She gave a history of typical ulcer pain for twelve years, had lost 20 pounds in weight in the preceding six months, and had a complete pyloric obstruction on arrival. She had had an appendectomy and excision of ovarian cysts in 1935. In 1936 a pregnancy had been terminated because of toxemia. With careful nonoperative management, the pyloric obstruction gradually relented and her general condition improved. On psychometric studies she had a low MMPI "K" score of 49. A score of 28 on the four-

teen significant SGI items placed her in the equivocal recovery-predicted group. On Febraury 25 a 75 per cent gastric resection was performed. The pathologist reported finding a chronic duodenal ulcer and pyloric stenosis with hypertrophy and dilatation of the stomach. She was discharged from the hospital on March 2 after a smooth convalescence. She was seen again on April 27, at which time, except for being under weight, she was getting along quite well. She returned to her home abroad shortly afterwards. Seven months later we were informed by her family that she was spending much time in bed and not working. This placed her in the poor recovery group. Other communications from her advised us that she was troubled with moderate occasional vomiting for several months after returning home and continued to stay markedly under weight.

A patient whose psychometric tests predicted a poor recovery.

A. O., a 34 year old white housewife, entered the hospital on March 20, 1948, as a county patient with an exacerbation of ulcerative colitis. Onset of the disease had been in the late summer of 1947, at which time she entered another hospital as a private patient. During her stay there she had miscarried (her second pregnancy, the first child being living and well). She was markedly anemic when transferred to the University of Minnesota Hospital in October 1947. After several blood transfusions, in November 1947 a transthoracic vagotomy was performed for her ulcerative colitis. This was her first operation. She did fairly well through the winter, experiencing some improvement in her colitis. An exacerbation brought her back into the hospital in March 1948, and ileostomy was considered. Psychometric studies in March showed her to have a low MMPI "K" score of 51. On the fourteen significant SGI items her score of 26 placed her in the poor recovery-predicted group. On April 5, 1948 an ileostomy was performed. Convalescence was stormy, with continued rectal discharge and the development of multiple subcutaneous abscesses which kept her hospitalized until in July. In September 1948, her husband, replying to the questionnaire, reported her to be getting along very slowly and not working, which placed her in the poor recovery group.

Summary

This investigation was undertaken in an attempt to discover whether any measurable aspects of a patient's personality could be correlated with his general recovery following surgical procedures. It was also hoped that some fairly simple test might be developed for use in predicting recovery.

The procedure used consisted of recording certain factual data about the patient, of his responding to the five hundred and fifty items of the Minnesota Multiphasic Personality Inventory, and of his giving graded answers to the fifty-seven items of the Schneider-Gray Inventory. This was done preoperatively. Postoperatively the patient's nearest relative or friend supplied information on the basis of which the patient's recovery was classified as either good or poor.

The investigation was successfully completed on 119 patients. Of the factual data, a correlation with recovery was found only in the case of multiple previous surgical procedures. For the psychometric data, it was found that the answers to fourteen items of the Schneider-Gray Inventory, when interpreted in the light of the Minnesota Multiphasic Personality Inventory "K" score (test-taking attitude), had a statistically significant correlation with the recovery result as reported by the patient's family.

This is a pilot experiment. It has been tried on a single series of patients. However, the method used predicted recovery with even greater accuracy on a subseries consisting solely of patients with "peptic" ulcer. Analysis of the data already obtained is still in process. Much more study must be done and many more trials made on other series of patients before such a test can be readied for other than experimental use.

The authors believe that this type of investigation bids high for eventual widespread usefulness. Such a test should ultimately be available as an objective means of predicting recovery so far as it is affected by the psychosomatic characteristics of the patient.

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AMERICAN PSYCHIATRIC ASSOCIATION TO PRESENT TRAINING SEMINAR

A training seminar for psychiatrists and the general medical profession will be presented by the American Psychiatric Association at Detroit on April 30, under the auspices of the Committee on Medical Education of the American Psychiatric Association. The Fort Wayne Hotel will be the headquarters for the program, which will precede the opening of the one hundred and sixth annual meeting of the American Psychiatric Association.

Enrollment will be limited to physicians ($10.00) and to medical students, interns, and residents ($2.00). The fee covers the cost of a buffet luncheon. Subjects to be covered include psychologic aspects of child feeding, new attitudes toward childbirth, emotions and the respiratory tract, psychiatric problems in old age and psychosomatic considerations of the gastrointestinal tract.

Inquiries should be directed to the Committee on Medical Education, American Psychiatric Association, 1624 Eye Street Northwest, Washington 6, D. C.

Varicose Veins in Pregnancy*

By JAMES M. SULLIVAN, M. D.
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J. M. SULLIVAN

An assistant professor of surgery at Marquette University School of Medicine, Doctor Sullivan received his medical degree from that institution, later completing a residency in surgery at the State of Wisconsin General Hospital. A diplomate of the American Board of Surgery and a member of the American College of Surgeons, he also maintains a private practice in Milwaukee.

VARICOSE veins occur predominately, in a ratio of 4 to 1, in the female and, since they are usually initiated in the second, third, and fourth decades of life, namely, the child-bearing period, the problem of treatment during pregnancy is a very pertinent subject.[1]

The current antipathy to actively treat varicose veins in pregnancy seems to have crept into the literature from earliest antiquity. Ritchie[3] credits Ambrose Pare, the barber surgeon, who was the first one to advocate ligation of the saphenous vein in the thigh (1579), with the statement that it is best not to meddle with varicose veins during pregnancy. Sherman,[7] as recently as last year, states that active treatment for varicose veins should be deferred in the female until after the menopause, because they will be aggravated by each pregnancy. McPheeters[4] and Linton[2] advise waiting until pregnancy is over before instituting treatment. Practically all the recent textbooks give no specific advice on the pregnant woman or advise conservatism.[8, 10] No one, however, gives any specific reasons why surgical procedures should not be performed during pregnancy. Shank in 1948[5] and Peyton and Loop[2] in 1949 have in recent articles been very enthusiastic about treating varicose veins during pregnancy and are continuing to do so.

Our own experience dates back to 1946, when, on the proddings of a local obstetrician and because of the fact that we could see no valid reason why pregnancy would be a contraindication, we started to treat patients. On the positive side we have found that in a recent series of thrombophlebitis that we have analyzed,[9] 50 per cent of them had pre-excising varicose veins, and, therefore, for prophylactic treatment alone therapy seems indicated. Then again varicose veins seem to be in most cases a progressive disease, and the longer treatment is delayed, the more difficult the treatment becomes. If delay is to be cautioned throughout the entire child-bearing period, fifteen to twenty years may elapse, and by that time the sequelae of varicosities may have made their appearance; namely, extensive stasis dermatitis and varicose ulcers with their attendant morbidity.

Etiology

Innumerable factors aside from sex and age have at one time or another been given as causes for varicose veins. My personal observations would put heredity as the single most important factor. Many cases occurring in the same family are so frequent that this fact is almost taken for granted in the routine history. This may be due to (*a*) congenital weak valves (faulty development), or (*b*) congenital weak connective tissue.

Conditions often associated with varicose veins due to weak connective tissues are enteroptosis and hernia. Mechanical venous obstructions caused by pregnancy, tumors in pelvis, and tight garters, although often indicated as the cause for varicosities, are difficult to prove.

Other etiologic factors are increased vascularity of the pelvic veins occurring during (*a*) puberty, (*b*) menopause, (*c*) menstruation, or (*d*) pregnancy. Varix occurring in the early months disproves the mechanical factor of pregnancy as the sole cause. Other causes sometimes mentioned are occupations requiring long standing, lack of vitamin C, arteriovenous aneurysm, and thrombophlebitis of deep veins with compensatory dilatation of superficial veins.[8]

Anatomic Physiology of Varicose Veins

The long column of blood from the right side of the heart to the ankle veins put a tremendous pressure on the veins of the leg. The deep veins of the leg, being enclosed by muscle and fascia, are well equipped to take this pressure, but the saphenous system is minus this protection and the thin walls of hereditary weak veins are ill-fated to withstand these pressures. Certain factors help in withstanding this pressure.

The sump, or overflow, effect of the right side of the heart helps to dissipate this hydrostatic load, but intra-abdominal increase in pressure due to straining, etc., mitigates the sump effect of the heart and increases the pressures in the distal veins.[6] Competent valves at the saphenofemoral junction and at the communicating veins prevent too great a load on the saphenous system. Contrariwise, incompetent valves produce a closed uninterrupted hydro-

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* Read before the One Hundred Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

From the Department of Surgery, Marquette University School of Medicine.

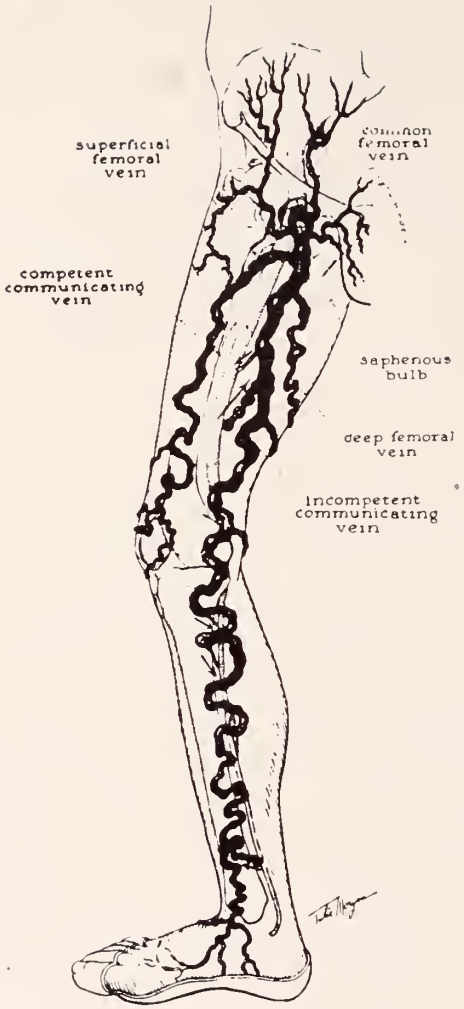

Fig. 1.—Varicosities of the long saphenous system and a deep communicating vein (from Barone[1]).

Fig. 2.—Varicosities of the short saphenous system and the femoropopliteal vein (from Barone[1]).

static system which is free to obey Pascal's law that pressure exerted upon an enclosed fluid is transmitted undiminished in all directions and acts with equal intensity on all surfaces. The weakest point being the saphenous system, varicose veins will, therefore, occur here.

In the presence of incompetent valves, retrograde flow of venous blood will occur, producing stagnation, anoxia of blood and tissues, with the sequelae of stasis dermatitis followed by varicose ulcers.

Diagnosis of Varicose Veins

Figure 1 illustrates varicosities of long saphenous system with an incompetent communicating vein in the thigh. Particular note should be made of the numerous branches at the saphenofemoral junction.

Figure 2 illustrates varicosities of the short, or lesser saphenous system. This system is involved in about 10 per cent of cases of varicose veins and is almost always accompanied by involvement of the greater saphenous system.

Once varicose veins are diagnosed by inspection, patency of the deep veins must then be determined before proceeding with any treatment. This is best determined by semielastic compression of the extremity and having the patient walk vigorously for a period of time. If the symptoms are relieved the deep veins are patent, but if the symptoms are aggravated caution is warranted.

The Trendelenburg test is then used to determine the competency of the long saphenous valves.

Figure 3 shows the beginning steps in the performance of this test. The insert shows the patient standing and the varicosities are very easily visualized. No. 1 shows the patient lying down with the leg elevated and the veins being emptied. No. 2 shows the constrictor being applied.

Figure 4 shows the patient standing with the constrictor in place and the veins empty. When the constrictor is suddenly released there is a quick filling of the veins from above. This means that the

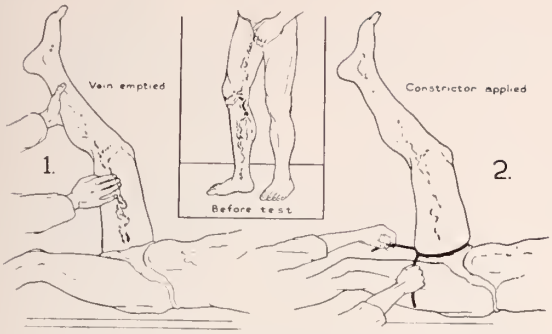

Fig. 3.—Steps in the Trendelenburg release test for incompetence of the long saphenous valves (from Barone[1]).

saphenofemoral valve is incompetent and is known as a Trendelenburg positive test. Ligation at this level is necessary.

If when the tourniquet is released there is no sudden filling of the veins from above, it means the valve is competent and able to maintain the column of blood. This is known as a negative Trendelenburg test.

Figure 5 illustrates the findings when there is also incompetency of the communicating valves besides incompetency of the saphenofemoral valve. In spite of the constrictor being in place, the veins quickly fill from above when the patient stands. In these cases this test can be repeated at various levels to accurately localize the faulty valves and to determine their number.

Other tests to confirm the findings of the Trendelenburg test are the Schwartz percussion test and Adams' percussion test.[6]

Treatment

This may be divided into conservative and active. Under the conservative are measures to support the saphenous system, such as elastic bandages, elastic stockings, Unna paste boots, etc.

Active or surgical treatment is determined by the pathologic changes present. In the case of minor varicosities with no incompetent valves, sclerosing solutions such as sodium morrhuate or Sylnasol may be used to sclerose the veins. These cases are usually asymptomatic and treatment accomplishes only cosmetic or prophylactic results.

More severe varicosities, with incompetency at the saphenofemoral junction, require that the vein be tied at this point close to the femoral vein and that all branches in the vicinity be tied so that these small veins do not take over the re-routing of the blood from the incompetent valve around the liga-

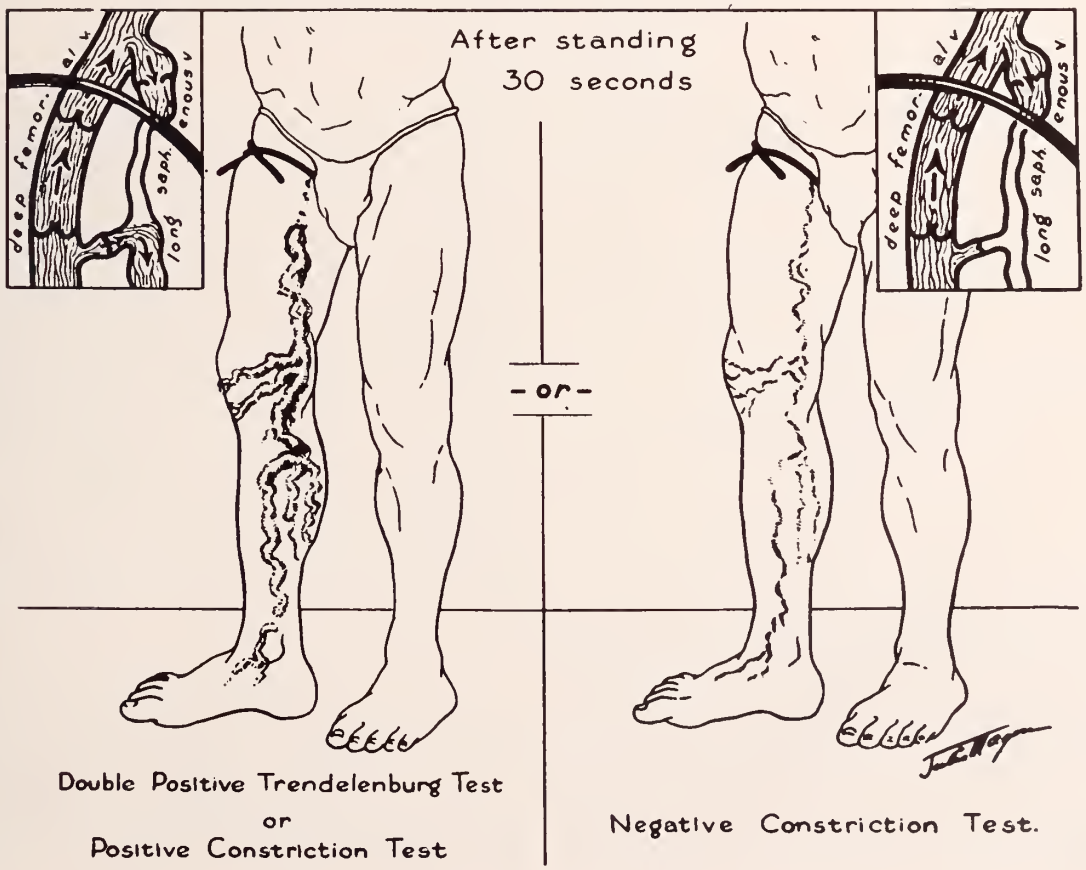

Figure 4 (from Barone[1]).

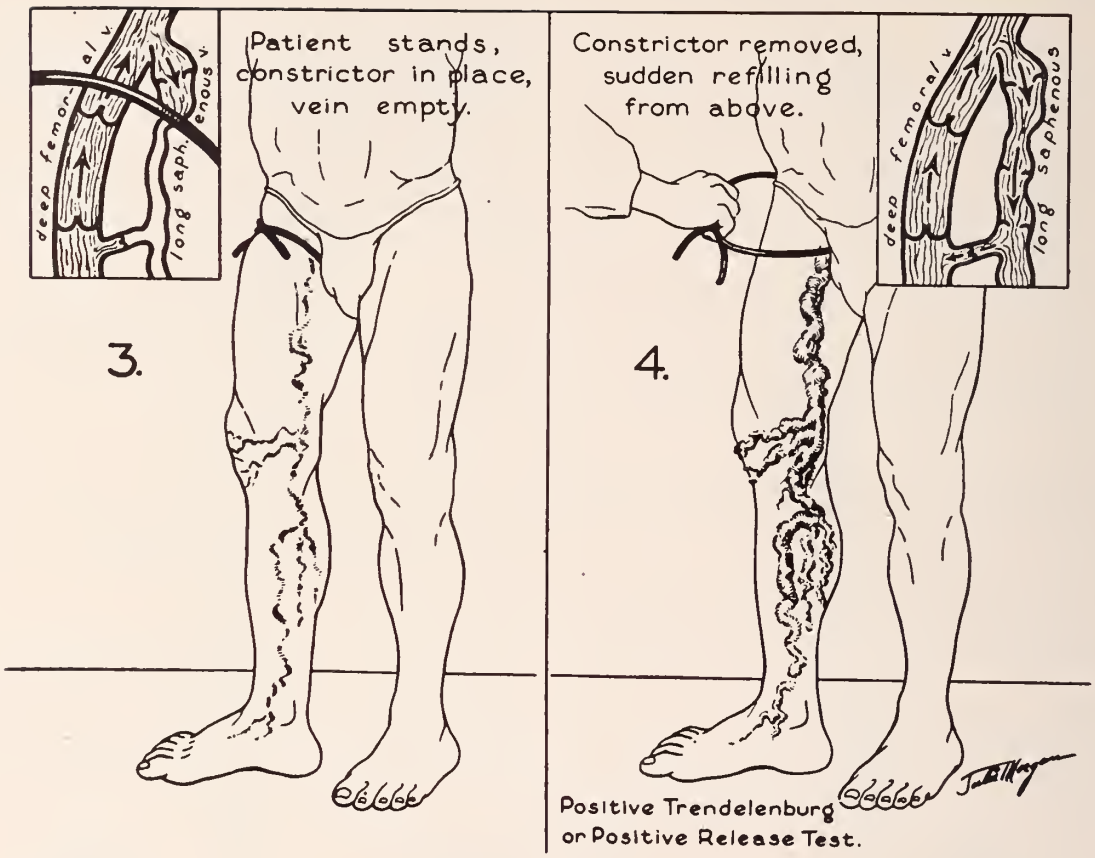

Figure 5 (from Barone[1]).

tion and into the distal end of the vein with continuation of the pathologic process, as illustrated in figure 6.

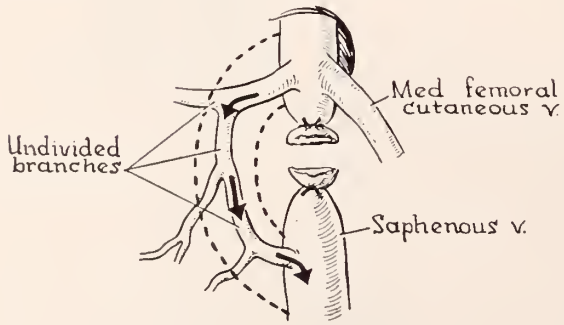

Figure 6 (from Pratt[11]).

Figure 7 graphically depicts the steps in a satisfactory high saphenous vein ligation. The incision we use is made slightly medial to the pulsation of the femoral artery, beginning at the inguinal ligament and made in the direction of the vein for a distance of about 2 to 3 inches. By blunt dissection the vein is exposed and dissected free. All branches are tied and cut and the vein itself is tied and severed close to its junction with the femoral vein. Distal injections are not given at this time because these have been found to be too uncomfortable to the patient. Interrupted cotton sutures are used to tie the vein and for closure. Even in cases of a single positive Trendelenburg sign we routinely pick up the saphenous vein again just above the knee and just below the knee and again doubly ligate and sever it. In the cases of a double positive sign, additional ligations are necessary at the levels of the faulty communicating valves. Any remaining veins are injected later on in the office. The use of a Babcock type stripper of the intraluminal type facilitates locating the saphenous vein for tying above and below the knee in the cases in which this is difficult. Stripping of the entire saphenous system is used in the very severe conditions, but this requires that the patient be hospitalized for a few days and the administration of a general or spinal anesthetic, and, therefore, we do not use it routinely. Minor blow-outs which have been missed at the first operation can be very easily ligated in the office on subsequent visits.

Analysis of Cases

We have 34 cases of pregnant women who had operative treatment of their varicosities during pregnancy, and selected 39 other similarly treated patients who were not pregnant for comparison. Table I gives the preoperative status of these two groups of cases. The average parity of these pregnant patients was three, with the highest being Para

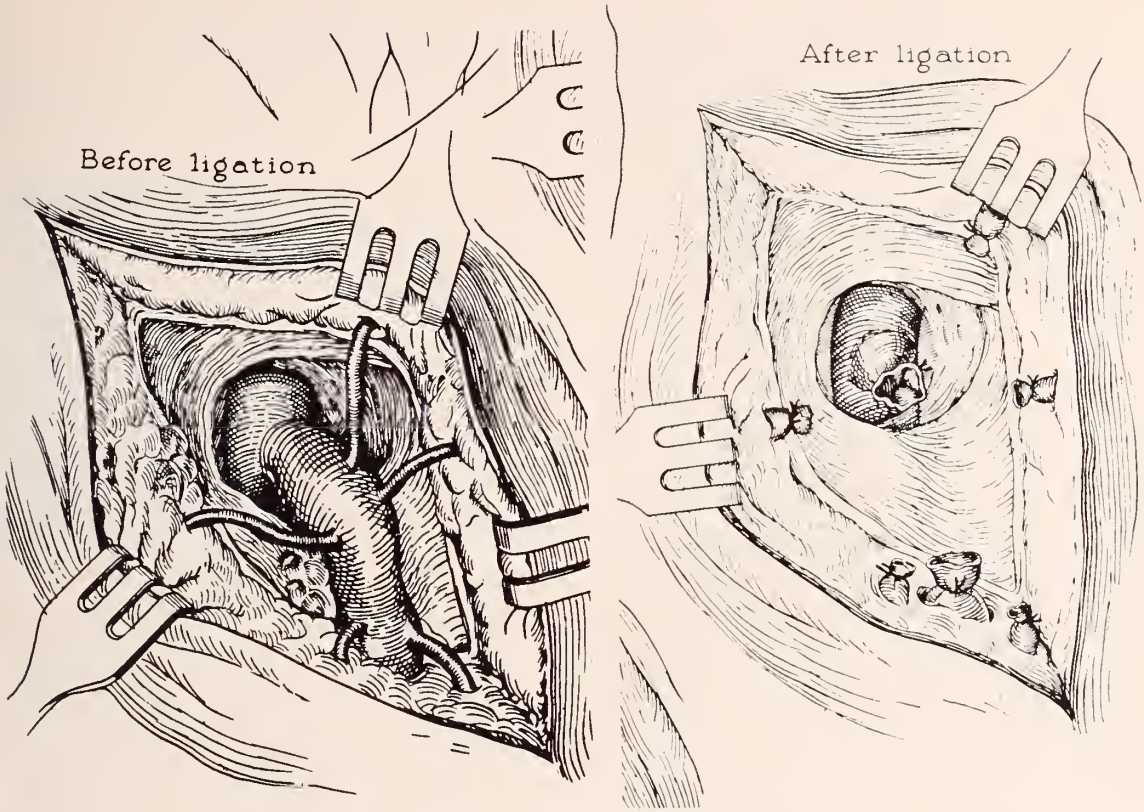

Figure 7 (from Barone[1]).

8 and the lowest Para 1. The duration of symptoms averaged ten and one-half years in the nonpregnant and only four and a half years in the pregnant. This is probably explained by the fact that most patients have heard from their obstetrician that it is unwise to treat varicosities until after the childbearing period and they have, therefore, been permitted to suffer with their disease for a much longer time. One patient had her disease for thirty years before seeking active treatment. This in the nonpregnant group. In 27 per cent of the pregnant

TABLE I

	No. of Cases	No. of Pregnancies (Average)	Duration (Average)	Unilateral	Bilateral
Pregnant	34	3	4½ yrs.	72%+	27%
Nonpregnant	39	0	10½ yrs.	58%	41%+

patients the condition had become bilateral at the time of treatment and in over 41 per cent of the nonpregnant patients it had become bilateral. This fact is probably also related to the longer duration of the varicosities in the latter group.

Table II shows the results of treatment in the cases we were able to follow up. We thought that the number of postoperative injections given in each group would give some indication of whether the pregnant patients would be more difficult to treat than the nonpregnant. The average number of postoperative injections given to the pregnant patients was 3.09, varying from 0 to 9 injections and to the nonpregnant was 3.07 varying from 0 to 17 injections. These figures are so close as to be statistically nonsignificant.

TABLE II

	No. of Cases	Postoperative Injections, Average	Results,	
			Satisfactory	Poor
Pregnant	34	3.09	24	1
Nonpregnant	39	3.07	19	1

Follow-up cards were sent to all our patients asking them if in their opinion their operation was satisfactory or unsatisfactory. In the cases of pregnancy we have had twenty-five replies, with twenty-four satisfactory and only one unsatisfactory. In the cases of nonpregnancy we had twenty replies with nineteen satisfactory and one unsatisfactory. These results would seem to indicate that the results obtained in the cases of pregnancy were at least as good as in those of nonpregnancy if not slightly better. Since I gave all treatment to all the patients personally, I feel that this is a significant and fair

comparison. To go even further than the figures would warrant, I feel the pregnant patients were easier to evaluate and treat, because the pathologic varicose veins were temporarily made more prominent by the pregnancy, blow-outs could be more readily detected and corrected, and the remaining veins could be more readily visualized for injection. Our failure in both groups of cases was in each case due to the overlooking of blow-outs that could have been corrected if recognized. This shows the importance of proper evaluation and complete correction of the pathologic process, regardless of whether the patient is pregnant or not.

Conclusions

1. Heredity seems to be the single most important cause of varicose veins.

2. Although the medical literature abounds with advice against treating varicose veins in pregnancy, no evidence supports this advice.

3. Satisfactory treatment of varicose veins requires a thorough knowledge of the anatomic physiology, proper location of the blow-outs, and thorough surgical correction.

4. In a series of 34 cases of varicose veins treated during pregnancy compared with a series of 39 cases of varicose veins treated in nonpregnant patients, the results achieved were as good if not better in the pregnant group than in the nonpregnant group.

5. It is therefore felt that varicose veins may be satisfactorily treated during pregnancy.

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UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ANNOUNCES PROGRAM FOR ALUMNI DAY

The Alumni Committee of the University of Wisconsin Medical School, under the chairmanship of Dr. Harold M. Coon, superintendent of the State of Wisconsin General Hospital, has completed a tentative program for the annual alumni day, to be held May 18 at the medical school. All alumni are urged to attend the event. Honored class this year is the Class of 1930, celebrating its twentieth anniversary.

Guest speaker will be Dr. John Morrison, New York, a graduate of the class of 1927, and his presentation will be given in the auditorium of the Service Memorial Institutes Building at 4:40 p. m., immediately preceding the social hour and dinner. This year's program, which is partially printed below, will include more of the grand rounds clinics and fewer scientific papers. Unless otherwise indicated, the events below will take place in the Service Memorial Institutes Building.

Grand Rounds

8:00– 9:00 a. m.: Medicine—W. S. Middleton, M. D., Dean
9:00– 9:30 a. m.: Pediatrics—John E. Gonce, M. D., professor of pediatrics
9:30–10:00 a. m.: General Surgery—Erwin R. Schmidt, M. D., professor of surgery
10:00–10:30 a. m.: Obstetrics—John W. Harris, M. D., professor of obstetrics and gynecology
10:30–11:00 a. m.: Neuropsychiatry—William J. Bleckwenn, M. D., professor of neuropsychiatry
11:00–11:30 a. m.: Orthopedics—Robert E. Burns, M. D., professor of orthopedic surgery

Scientific papers

11:30 a. m.: Robert C. Parkin, M. D., coordinator of graduate medical education
11:50 a. m.: John W. Barnard, M. D., associate professor of physiology

Luncheon (place: second year laboratory)

Inspection of student exhibits at 2 p. m.

Grand Rounds

3:00–3:30 p. m.: Dermatology—Sture A. M. Johnson, M. D., professor of dermatology
3:30–4:00 p. m.: Otolaryngology — Wellwood M. Nesbit, M. D., professor of otolaryngology

Scientific papers

4:00–4:20 p. m.: Dr. Alexander M. MacKay, associate professor of anesthesia
4:20–4:40 p. m.: Robert W. Quinn, M. D., associate professor of preventive medicine
4:40 p. m.: John Morrison, M. D., New York, Guest Speaker

A social hour and dinner, beginning at 6 p. m., will be held at the Blackhawk Country Club.

Misconceptions in Neuro-Ophthalmology*

By P. J. LEINFELDER, M. D.
Iowa City

P. J. LEINFELDER

A professor of medicine at the State University of Iowa, Doctor Leinfelder is a native of La Crosse. He received his M.D. degree from the University of Wisconsin Medical School in 1929 and interned at the State of Wisconsin General Hospital, completing a residency in ophthalmology at the State University of Iowa in 1935. The following year he joined the staff at that institution as assistant professor of ophthalmology.

ERRORS in diagnosis in neuro-ophthalmic disease frequently occur because of misinformation and misconceptions concerning the significance of signs disclosed by ocular examination. Changes in visual acuity, anomalies of ocular rotations, visual field deficiencies, and ophthalmoscopically observed abnormalities may make the causation obvious, but frequently these findings must be carefully and correctly interpreted in order to make an exact diagnosis. Sometimes when most complete study of the patient fails to explain his symptoms, reexamination at later dates may disclose the nature of the pathologic process.

Occasionally the failure to appreciate changes in visual acuity leads to errors in diagnosis. All changes in visual acuity are not due to refractive errors or ophthalmoscopically discoverable changes, nor should it be assumed that they result from unknown causes. Retrobulbar neuritis, or any disease process that affects the visual pathway from the ganglion cells of the retina to the occipital cortex can cause changes in visual acuity that cannot be corrected by lenses, and may not be accompanied by ophthalmoscopic evidence of disease. In many cases multiple sclerosis or brain tumor are passed over because of misconceptions of the importance of changes in visual acuity. Every patient with unexplained loss of visual acuity should be suspected of having neurologic disease and have visual field studies done. One should be particularly alert for pituitary tumor, Foster Kennedy's syndrome, sphenoidal ridge meningioma, multiple sclerosis, temporal lobe tumor, and von Recklinghausen's disease.

Visual field studies disclose evidence of disease or affection of the visual pathway that is the result of inflammation, degeneration, vascular disease, or pressure. Demonstration of change in the visual field is usually indicative of the presence of a pathologic process, but frequently too much reliance is placed upon the results of a single test. This is particularly true when there is a concentric contraction of the visual field, for often this phenomenon is the result of fatigue or inattention. Repetition of visual field studies may show that the extent of deficiency is not as great as was first demonstrated. Proper technics are necessary for accuracy because marginal defects may be overlooked when inaccurate methods are used. In using the tangent screen at 1 meter distance, accurate results are obtainable only when a 1 mm. test object is used. The theory of isopters clearly indicates that 3 or 5 mm. test objects show defects only when the disease process affecting the visual pathway is far advanced. In the same manner, care must be exercised to select the proper test object when working with the perimeter. Ordinarily the 3 mm. white target is preferred.

Although much has been written concerning macular sparing, the value of these reports has been of anatomic and physiologic interest rather than clinical. As yet no adequate explanation for the occurrence of macular sparing is available, but it is a clinically recognized fact substantiated by pathologic examination that it may be demonstrated in some occipital lobe lesions, but not in others that are identical in location and extent. Furthermore, since macular sparing has been demonstrated in patients who had proved lesions at the optic chiasm or in the optic tracts, it may be concluded that no diagnostic localizing significance can be placed on it.

Bitemporal hemianopsia is not invariably the result of a primary lesion in the region of the sella turcica. Posterior fossa tumors which cause obstruction of the aqueduct of Sylvius, and internal hydrocephalus often result in dilatation of the third ventricle and pressure on the optic chiasm, with the production of bitemporal hemianopsia.

Edema of the nerve head is an important diagnostic sign in intracranial disease, but the absence of choked disk in a patient is not an assurance that a brain tumor does not exist. The statistics with which most of us are familiar indicate that 80 per cent of patients with brain tumor have papilledema. These figures were obtained from studies made twenty-five or more years ago, but, since then, great advance has been made in neurologic and neurosurgical diagnostic methods. At present only 40 to 50 per cent of patients with brain tumor have choked disks at the time of recognition of the disease.

The diagosis of choked disk is not always easy. An erroneous impression of early choked disk may occur when the neurologist refers a patient whom he suspects of having a brain tumor, for under such

* Read before the One Hundred Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, 1949.

circumstances slight physiologic variations in the appearance of the papilla may be more readily misinterpreted. Many patients have blurred disks normally, and, in some, even similarity to choked disk may be seen. Pseudochoked disk should be suspected when the veins are of normal size, the borders of the nerve head are relatively translucent, and hyperopia is present. At times repeated examination at daily or weekly intervals may be required before one may make a diagnosis with certainty.

Edema of the nerve head is not invariably seen with increased intracranial pressure, and occasionally choked disk occurs in patients with brain tumor in whom there is not a measured increase in cerebrospinal pressure. Papilledema is usually gradual in development. Reports of edema observed immediately following skull fracture are usually in error, but after twenty-four hours papilledema may be definitely recognized. Sometimes choked disks do not occur until after intracranial surgical procedures for the removal of a tumor, or there may be an increase over the amount of the edema present preoperatively. This is particularly true when the operative interference was accompanied by considerable manipulation and destruction of tissue because this is followed by extensive swelling of the brain. The tight bandages so commonly used also restrict the functions of the decompression and the postoperative intracranial pressure may be greater than it was initially. The use of postoperative spinal taps has definitely diminished this complication.

The regression of papilledema is a gradual process. It is unusual for choked disks to disappear in a few days, for even when there is a favorable result from the operation, edema of the disk may persist for two or three weeks. There usually is a slow diminution of the swelling, but at times this may not be apparent up to ten days or two weeks. However, if choked disks are still present three weeks after operation, one may conclude that the surgical interference has not been adequate. One exception to this occurs in the syndrome of pseudotumor in which condition some degree of edema of the disk may persist for years after decompression without recognizable injury to the optic nerve.

Choked disk may be confused with papillitis and neuroretinitis. Papillitis may be differentiated only on the basis of the loss of visual acuity that occurs concurrent with its onset, for its appearance may be indistinguishable from that of choked disk. Occasionally in hypertensive vascular disease or arteriosclerosis one encounters swelling of the nerve head that has the same appearance as choked disk caused by brain tumor. This appearance indicates increased intracranial pressure but in this instance it usually is due to cerebral edema and not to tumor. Differentiation depends upon the recognition of the typical vascular changes in the retinal arteries. Rarely vascular diseases and a brain tumor may be present in the same patient.

The ophthalmoscopic appearance of the nerve head does not invariably allow one to make or disprove a diagnosis of optic atrophy. Measurement of the extent of degeneration must be determined by visual field study. One may gain an impression of atrophy by inspection of the nerve head, but positive diagnosis and determination of the degree of impairment is made by the demonstration of visual field loss. Some nerve heads appear pale, but are normal, while in some instances normal appearances occur with atrophic nerves. Pallor is the result of gliosis and consequent constriction of the capillaries in the papilla; under some circumstances gliosis is more extensive and secondary type of atrophy occurs, while in others it is minimal and primary atrophy develops. However, the ophthalmoscopic differentiation between primary and secondary atrophy cannot always be made, since the amount of gliosis is dependent upon factors other than the cause.

It is particularly dangerous to consider temporal pallor as an indication of optic atrophy due to multiple sclerosis. Retrobulbar neuritis does produce atrophy of the temporal segment of the nerve head, but when this occurs a central scotoma is present and visual acuity is reduced. Occasionally multiple sclerosis causes a slowly developing generalized atrophy of the optic nerve. Among some physicians there has been a tendency to associate retrobulbar neuritis with sinus disease. However, many ophthalmologists have never encountered such a relationship and it is perhaps true to say that it rarely if ever exists. When improvement occurs following sinus treatment, be it medical or surgical, it is probable that such improvement is coincidental, for return of vision sometimes occurs without any treatment.

Of the many misconceptions concerning the activity of the extraocular muscles, the greatest is the tendency to attribute all defects to the muscles themselves. Since the muscles respond to the requirements of the central nervous system, it is in the nervous system that one most frequently finds the reason for motor anomalies. Mechanical interferences with the action of the muscles can be compensated for to a surprising degree by a normal nervous system and single binocular vision preserved. This can be observed in slowly developing unilateral exophthalmos. Similarly, slight changes in the insertion of the extraocular muscles in the normal eye does not disrupt binocular activity. The potentiality of the normal nervous system in overcoming anomalies in ocular rotation and the possibilities of diseases to produce them must always be kept in mind.

In conclusion, it should be emphasized that the current impression that neuro-ophthalmology is difficult is erroneous. Although the literature is extensive, much of it concerns rare diseases or variations in the commonly encountered conditions that are not of great clinical significance. A knowledge of the gross anatomic structures of the brain and the relationship of the visual pathway and the oculomotor system to them gives an adequate basis upon which the disturbed anatomy and physiology in disease may be interpreted.

Complications of Diabetes*

By FRANCIS D. MURPHY, M. D.
Milwaukee

F. D. MURPHY

Professor and head of the department of medicine at Marquette University School of Medicine since 1928, Doctor Murphy received his M.D. degree from that institution in 1920. He entered practice in Milwaukee that same year and in 1924 gained his master of science degree from the University of Pennsylvania. He is clinical director of the Milwaukee County Hospital and has been chief of staff at St. Joseph's Hospital since 1947.

DIABETES is known as a disease characterized by many and various complications. It is the complications which develop and often convert simple, comparatively benign diabetes into a serious and frequently fatal disorder. In 1930 my colleagues and I reported on the complications of 827 cases of diabetes mellitus,[1] dividing them into seven classes: coma, cardiorenal vascular disease, infections, tuberculosis, carcinoma, syphilis, and a miscellaneous classification. Of the cases, 82.37 per cent were complicated by one or more disease, the most common finding being arteriosclerosis.

During the last twenty-five years, or since the introduction of insulin, complications have taken on greater significance, and the incidence of certain of them has changed. Death from diabetic coma is rarely seen today, and tuberculosis, which was a common finding, has become less frequent. However, arteriosclerosis has become more prominent and is often the immediate cause of death. Coronary arteriosclerosis, cerebral arteriosclerosis, and arteriosclerosis involving the extremities are the chief complications found today. Infections which in the past were not only common but frequently fatal have become controlled to a large degree.

One could hardly discuss diabetes without taking up briefly the problem of diabetic coma. Diabetic coma can hardly be called a complication in the sense that other disorders are, as it is really a part of diabetes itself. Every diabetic person must learn how to prevent coma and should be instructed in the events which indicate that coma is pending. Naturally, of course, every doctor must know in detail how to recognize and treat the earliest stages of coma. The differentiation between the coma and precoma stage is often difficult, but from the practical point of view, the treatment is essentially the same in both stages. Every diabetic person is a candidate for diabetic coma. There are three main causes of coma in the diabetic person: (*a*) interruption of the use of insulin; (*b*) excessive food or breaking the dietary regulations; and (*c*) infection or trauma.

The clinical features which indicate that coma is imminent may be considered under two main syndromes: dehydration and ketosis. While both merge to produce the classic picture, their separation may be helpful from the point of treatment.

In the dehydration syndrome the skin is dry and inelastic and the face flushed and drawn but without fever. The mouth is dry, with a tongue that is red, beefy, and coated, and the eyeballs are soft and sunken back in their sockets. The pulse is weak and its volume reduced and at the same time the blood pressure is low, and the heart tones are rapid, distant, and weak. Oliguria and then anuria develop.

When ketosis is present the following symptoms are characteristic: *(a)* the breath has a peculiar sweet odor; *(b)* breathing is deep and low; *(c)* Sugar, acetone, and diacetic acid are found in the urine; *(d)* elevation of the blood sugar is seen; and, *(e)* there is a drop in the carbon dioxide-combining power of the blood to 20 volumes per cent or lower.

Since coma is an acute emergency, the patient should be hospitalized where immediate laboratory service is available. General measures are advocated, such as keeping the patient warm, drainage of the bladder, determination of the blood sugar content, and administration of circulatory stimulants, such as coramine, 4 to 6 cc., or caffeine, 0.4 Gm., which may be given intramuscularly and repeated every four to six hours if necessary. Gastric lavage and a cleansing enema may also be of value. Specific therapy should be aimed at treating the ketosis with large doses of insulin and administering an abundance of fluids to overcome dehydration.

The complication which seems to catch the imagination of most investigators is chronic intercapillary glomerulosclerosis. Although formerly nephritis and other kidney diseases (renal arteriosclerosis) were recognized and discussed, in 1936 Kimmelstiel and Wilson introduced their work on glomerulosclerosis,[2] and since that time more attention has been given to the kidney in diabetes.

Although we do not know the exact nature, pathogenesis, or cause of glomerulosclerosis, we do know some important things about it. On taking a panoramic view of all the diabetic patients whom I treated during the last twenty-five years, I know that chronic glomerulosclerosis is a disorder that often occurs among young individuals, that is, under 35, though it is perhaps more commonly seen in the

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

older diabetic patients. It develops in diabetic persons who have carried the disease for fifteen years or over and, finally, and most important of all, it is the price which a diabetic person pays for neglecting his disease. While it may occur in patients who have controlled the diabetes, in my practice I would say it occurs almost entirely among the diabetic patients who have allowed themselves to lapse into the uncontrolled group.

In a study of the renal lesions of diabetic patients at the Milwaukee County Hospital made by Shiffler and Murphy this year,[3] it was found that in 76 cases in which autopsy was performed on diabetic persons with some renal complications, arteriosclerosis, arteriolosclerosis and intercapillary glomerulosclerosis were common findings, arteriosclerosis and glomerulosclerosis often occurring in the same kidney. The fully developed lesion of Kimmelstiel–Wilson disease occurs only rarely in the nondiabetic person and may be expected to occur in approximately 35 per cent of the cases in which autopsy is performed. Its incidence increases with age, and it is most frequent in the person with mild diabetes whose disease is long standing, reaching a peak in the seventh decade.

Chronic glomerulonephritis occurs in association with diabetes at times, and the differentiation between it and chronic intercapillary glomerulosclerosis is not always easy to make. When one considers the following points, diagnosis is much easier:

1. Red cells and casts are common in glomerulonephritis, not so common in glomerulosclerosis.

2. When hypertension, edema, albuminuria, and retinitus occur in the diabetic patients, it is probably glomerulosclerosis.

3. A very important point is that once glomerulosclerosis sets in it is too late to head off the fatal outcome.

Therefore, it cannot be emphasized too positively that it is especially important that the younger diabetic patient control his diabetes with great caution.

There has been a good deal of discussion about the nature and pathogenesis of the intercapillary lesions in Kimmelstiel–Wilson disease. Kimmelstiel and Wilson considered these lesions as an outgrowth and hyalinization of intercapillary connective tissue. Bell[4] considers the intercapillary masses as being derived from the capillary wall and not from a growth of the intercapillary connective tissue. Further, he considers the diffuse form of intercapillary glomerulosclerosis as frequent in chronic glomerulonephritis—more so than in diabetic persons—but that there is a specially defined hyaline lesion which is characteristic of diabetes alone. The lesions are due to the splitting, thickening, and fusion of the basement membranes of the capillaries. Bell does not believe that the disease originates in the intercapillary tissue but from the capillaries themselves.

In summary, an attempt has been made to emphasize the various complications of diabetes mellitus. It is the complication which converts a comparatively innocent diabetic condition into a serious and often fatal disorder. It has been emphasized that the adequate control of the diabetic over many years, especially in the earlier period of life, is the most important factor in prevention and control of the serious complications.

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WISCONSIN SOCIETY OF ANESTHESIOLOGISTS SCHEDULES SPRING MEETING

The spring meeting of the Wisconsin Society of Anesthesiologists will be held on May 7 at Madison, in the quarters of the department of anesthesia of the Wisconsin General Hospital. The program will be presented by the residents in training in the state, from the Veterans Administration Hospital, Wood; Milwaukee County Hospital, Milwaukee; and Wisconsin General Hospital, Madison. Dr. Larry Hogan will serve as chairman.

The complete program is as follows:

10:00 a. m.: "Carbon Dioxide Transport"—L. F. Thurwachter, M. D.
10:45 a. m.: "Carbon Dioxide Analysis of Anesthetic Atmospheres (demonstration)"—Ann Bardeen, M. D.
11:15 a. m.: "Toxicology of Local Anesthetic Drugs"—John Steinhaus, M. D.
12:00 noon: Luncheon
2:00 p. m.: "Mechanical Aspects of Spinal Anesthesia (demonstration)"—Karl Siebecker, M. D.
2:30 p. m.: "Newer Analgesic Drugs"—J. Judith Novak, M. D.
3:00 p. m.: "Physics of Respiration (demonstration)"—Gordon Garnett, M. D.
3:30 p. m.: "Shock"—John L. Burns, M. D.

Reservations for the luncheon may be made with Dr. Larry Hogan, Department of Anesthesia, Wisconsin General Hospital, Madison 6, at a charge of $2.00.

Anesthesia, the Weakest Link in the Surgical Procedure*

By IVAN B. TAYLOR, M. D.
Detroit

I. B. TAYLOR

Doctor Taylor, director of the department of anesthesiology at the Detroit Receiving Hospital, graduated from the University of Michigan Medical School in 1932, interning and serving a residency at the State of Wisconsin General Hospital. In 1938 he joined the staff of the University of Pennsylvania Hospital, serving as director of anesthesiology for three years. He has been professor of anesthesiology at Wayne University College of Medicine since 1941.

SURGICAL treatment of patients has progressed continuously during the last one hundred years. The surgeon's ambition is to further reduce mortality and morbidity as well as to offer hope for patients that have formerly been considered inoperable. All too often he may find that anesthesia is the factor that prevents full realization of these objectives. This weak point in his program can and should be improved.

Personal experience has convinced me that anesthesia is of utmost importance in many types of surgical procedures. It is also important to have safe anesthesia for the many ordinary elective operations. It seems to be particularly unfortunate when an anesthetic death occurs in a patient who is in fairly good condition undergoing an elective operation. The loss of such patients should be reduced to an absolute minimum. I have knowledge and data of deaths in many such patients and, in a recent report of the Anesthesia Study Commission for the City of Philadelphia,[1] nearly two-thirds of the anesthetic deaths in 300 patients were decided to have been preventable had the anesthesia been properly administered. Therefore, one cannot say that there are only a small percentage of patients that require skilled anesthesia administered by an anesthesiologist. It is true that in a certain percentage of the cases the immediate importance is much greater; however, the loss of patients in good condition to have relatively safe operations performed seems to be a very sad affair. It is to be expected that as anesthesiologists attempt to anesthetize patients in poor physical condition, who have surgical treatment as their only hope of recovery, they will encounter difficulties, as will the surgeon who attempts to save patients by extensive operations. This seems to be a responsibility that one must accept. In some communities there are surgeons trained and qualified to do surgical procedures that are not frequently done because of inadequate anesthesia.

Anesthesia involves the use of the most potent depressant drugs employed in the practice of medicine and the administration of these drugs to the most extreme degree. Also the time factor is very exacting, as one has only seconds and minutes to make a diagnosis and carry out necessary changes or treatment.

Anesthesiologists are the first ones to admit that surgical treatment within the thoracic cage was retarded because of lack of proper anesthesia for many years. Advances that have been made in this type of anesthesia along with others have been made by medical anesthetists, even though many of them may be carried out by others at the present time. There is an ever increasing tendency to do more extensive operations for conditions previously considered hopelessly inoperable. If anesthesia is well enough developed in the future, surgery will make progress in many communities. If we do not continue this progress and increase the number of anesthesiologists available throughout the country, anesthesia may continue to retard development of surgery.

One reads of the discovery of various new drugs in anesthesia, but these are of little importance compared to some of the other types of progress. The most important progress made in anesthesiology during the last two decades is the improvement in teaching and methods of disseminating knowledge amongst the medical profession, particularly those who are administering anesthesia. These improved methods of teaching that follow along the lines of other specialties in medicine have encouraged many young medical graduates to enter the specialty of anesthesiology. They have seldom been encouraged to enter this specialty because of financial advantages. It is generally conceded that the important advances in anesthesia are largely improvements in the administration of drugs and not in the type of drug itself. It is a well accepted axiom now in our own specialty that the skill and care with which the drug is administered is more important than the choice of the drug. The literature abounds with indications and contraindications, with theoretic instructions for choosing drugs and technics for various types of surgical procedures. However, this does not make for good anesthesia unless these methods are properly carried out during the administration.

In spite of the improved teaching methods and the relatively large number of teaching centers, there is a lack of interest on the part of the medical

*Read before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

graduates to enter the specialty. One of the reasons for this lack of interest in anesthesiology no doubt arises from the lack of respect of this specialty from our colleagues. There is need in our specialty to interest not those who have failed in other fields but the best that the medical profession has to offer, and such individuals are more apt to be interested when respect for this specialty has developed.

It appears that improving the standing of anesthesiologists is an important issue for progress. One factor of prime importance in accomplishing this is to give the anesthesiologists standing in their communities that is parallel with other specialties. Anesthesiology is of necessity a consultation practice. For that reason, the other physicians have nothing to fear with regard to our proselyting their practice. However, if they wish to have the advantage of best anesthesia for their patients, it will be necessary for them to "go to bat" for anesthesiology. This many of our profession have been unwilling to do. The sooner the entire medical profession recognizes that it is to their advantage to support and work for proper conditions for the anesthesiologist, the sooner they will have his services for their patients. Only when the conditions under which the anesthesiologist works are satisfactory will it be possible to attract the best candidates for this work. This does not refer entirely to the income but to other conditions of the practice of anesthesiology. One feature that is not desirable to most physicians is the one of working for a salary in the employ of a hospital or other institution, particularly when other physicians engaged in clinical care of patients do not work for a salary. We find that men trained in anesthesiology usually prefer to work on a fee for service basis wherever the surgeons work on that basis.

Who has administered anesthesia during the past hundred years? This period is best divided into three parts for general discussion. These are from 1846 to 1900, from 1900 to 1925 and from 1925 to the present. During the first period nearly all anesthesia was produced by the inhalation method using ether, chloroform, or nitrous oxide. The most active group in anesthesia during the first few years of this time were dentists, and they made contributions to anesthesia. With more widespread use, young physicians were required to administer anesthesia, all too often without supervision or instruction. It was part of their duties before they could ascend to the important task of assisting the surgeon. Very few of them ever become interested or proficient in this task. There are accounts in the literature of how poorly anesthesia was administered and, as time passed, more emphasis was put on the importance of anesthesia. By the turn of the century a few physicians were doing and teaching good anesthesia. One hears tales that the administration of anesthesia during this period and even the next was frequently relegated to the orderlies or any other available layman because it was not considered a worth while task for a doctor. Unfortunately, this attitude still exists in the minds of many. It stemmed from ignorance; it is a human trait that things that one does not know much about in his own field may be sublimated to unimportance.

During the first quarter of this century much progress was made in anesthesia. One great step was the introduction of local and spinal anesthesia with procaine. This gave methods that the surgeon could use himself with one important feature—he could improve his technic. Surgeons did nearly all the studying of local and spinal anesthesia in this period. While these methods were not without hazard there was improvement in the methods and additions to medical knowledge. Another and perhaps the most important trend during this period was specialization in anesthesia by physicians. The physicians taught one another, and there was a beginning of very good publications on anesthesia. By the end of this period there were full time anesthetists and still more physicians doing good anesthesia on a part time basis.

The third feature of this period was the introduction of the practice of teaching nurses to administer anesthesia. This practire was not adopted in any other sizable country, partly because most of the countries considered giving anesthesia as the practice of medicine and it could be done only by a licensed physician or dentist. In England, for example, they still train many midwives—some even practice obstetrics, and uncomplicated deliveries in charity institutions were, at least until before the war, done by midwives; but they considered anesthesia sufficiently important that nurses were not allowed to administer same. Whatever the merits of the system of using nurse anesthetists may have been in the past or is at present, it is not a system that would have made for progress without physicians in the field. Regardless of past service rendered and future service to be rendered by nurses, they should not be allowed to stand in the way of progress. One must look further ahead than how to get by today.

The last twenty-five years have exhibited the greatest progress in anesthesia and the most important contributing factor in this progress is the introduction and use of improved teaching methods, improved dissemination of knowledge, most of which was known at the beginning of the period but by very few individuals. This teaching started in a few centers and gradually spread until now there are many. This has been both the cause and the result of increasing numbers of capable young physicians entering this specialty. This aspect of progress is far more important than the introduction of new drugs and methods which have, of course, been outstanding in this period.

At the present time there are three thousand members in one national anesthesia society alone, most of whom do anesthesia only or the major part of their time. And there are many other physicians who have become proficient in administering anesthesia. It is perhaps a fair guess that half of the

anesthesia administrations are done by physicians and their professional students. There are many anesthesiologists who work as consultants on a fee for service basis. These men are generally called for the most difficult type of anesthesia and frequently are of service to their colleagues in many other ways. Therefore, it is probable that more than half of the difficult cases are done by physicians.

There are many teaching institutions training anesthesiologists and these physicians will spend the rest of their lives working in that specialty. Steps are also being taken to provide short or continuation courses in anesthesia for practicing physicians who do anesthesia on a part time basis in many communities.

As already indicated, physicians in a community who want improvement can do much to help. If they have sufficient surgery and will cooperate they can secure a full time anesthesiologist if he is given proper working conditions, namely, the same as they have. They must not expect him to work for a salary while they work for fees. They must help convince the hospital that he is a physician and will work as such. We have found that many surgeons want professional anesthesia but do not want to be in any way inconvenienced to get it; others will arrange schedules to help sell the idea to their private patients and will treat their anesthesiologist as a colleague. The latter are the ones who find it possible to have the services of a professional anesthetist enabling them to concentrate on the operation without worry about the anesthesia.

Hospital administrators and boards of directors can do much to help improve anesthesia for their patients. Some of them have already gone on record as opposed to professional anesthesia, unless the anesthesiologist accepts a salary instead of independent practice. Fortunately, however, there have been and still are many broadminded and far seeing hospital administrators. These administrators, some physicians and some not, have done much to make progress in anesthesia. They have made teaching centers possible and even provided for research. We appreciate their cooperation and can say to them that they have done far more than they or anyone else realized to advance the science and practice of anesthesia. To those who either have not encountered or are contemplating how they can offer professional anesthesia to their patients it can be said that they can get such service without much added cost in most communities unless they are already exploiting their patients by excessive fees for anesthesia. But, unless their staff, particularly surgeons are interested, it is a difficult task and a very thankless one for the recipient. The most sought for arrangement is a staff appointment with privileges to work on a fee for service basis the same as the surgeons do. One recognizes that running a hospital without loss is not an easy task, but it appears that if progress continues as during the past twenty years, hospitals will not regret having made arrangements to permit and encourage anesthesiologists to help with their anesthesia problems in cooperation with the rest of the staff.

Considerable variation exists throughout the country in the personnel who administer anesthesia. True it is that there are different standards of practice in many aspects of medicine, but there is probably no branch of medicine in which there is such a range of difference in the standards prevailing as in anesthesia. Those administering anesthesia are nearly all included in this list: (1) fully qualified anesthesiologists; (2) physicians in training institutions supervised by fully qualified anesthesiologists; (3) physicians with limited training in anesthesia; (4) surgeons giving spinal or local anesthesia with some one else watching the patient during the operation; (5) surgeons giving spinal or local anesthesia without anyone watching the patient; (6) interns and medical students under proper supervision; (7) interns or medical students improperly or not supervised; (8) nurses trained to administer certain types of anesthesia; (9) nurses with little or no training; and (10) lay persons with little or no training. There are all sorts of combinations of these existing in various hospitals.

The number of capable young physicians who are choosing anesthesiology as a specialty has increased a great deal. This is in part due to their special interest in this field which is most apt to be aroused by examples of desirable practice of the specialty. As soon as all communities and our own profession learn to treat the medical anesthetist as a colleague and physician, we will be able to interest more capable young physicians in this specialty. The established teaching institutions for anesthesiology have struggled for the last twenty years to make improvements in teaching anesthesia. Before that time, there were few but some very good training centers. All too often the rest of the profession seem to feel that the poor anesthesia that exists throughout the country is the fault of training centers and that by some magic we should improve it. If they would make some effort for progress, it would help. The profession must learn that these anesthesiologists are well trained physicians who can be of assistance to them in the care of patients. Anesthesia is a consultant practice and we will not steal their patients. The service we have to offer will allow them greater freedom to concentrate on the operation and save them enough worries so that they should not begrudge their anesthesiologist a living income. Fully indoctrinated surgeons are willing to reduce their fees when necessary to have the service of an anesthesiologist. The internist should be interested in the safety and welfare of patients he refers for surgical treatment. He can use his influence to improve conditions. The general practitioner may be administering some anesthesia. Most of them are grateful to be relieved of this responsibility and others for the opportunity to learn more about the specialty so that they may become qualified to continue with this work.

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All physicians could help by using their influence to convince hospital administrators of the value of professional anesthesia. Some hospitals will not allow surgeons to bring in a medical anesthetist or permit them on the hospital staff. The author appreciates that the business of running a hospital with a minimum of loss is a complicated and oft-times difficult task. However, the primary purpose of a hospital should be to care for sick people, and no system which retards progress or prevents patients from receiving safe anesthesia is justifiable even though it is a good source of revenue to the hospital. Also it is not fair to surgical patients, because they are paying more than their share toward supporting the hospital. Hospital costs should be put where they belong, as determined by cost accounting. Fortunately, many hospital administrators have for years been farsighted and helpful in regard to anesthesia. One can predict that with the increased interest in anesthesia by the American Medical Association, the profession, the public, and hospitals which have made satisfactory arrangements for the services of anesthesiologists will not regret any apparent loss in income. It is a little shocking to talk to some hospital superintendents who presumably have dedicated their lives to care of patients and learn that their chief concern is income to the hospital rather than safety for the patients.

So many hospital staffs are very careful about who is permitted to perform operations in their hospital, but they do nothing to improve anesthesia over what it was some years ago. What a shame to have good surgeons, many operative procedures that are not safe because of the anesthesia and many new anesthetic drugs and methods that cannot be safely used. This is many times the responsibility of the hospital staff; they must convince the administrators of these needs and take steps to at least have anesthesia properly supervised. Generally, anesthesiologists prefer to work on a fee for service basis the same as other physicians. There are a number of irritating factors involved in being an employee of a hospital, particularly when others of the surgical team are not. These undesirable features are not absent in a hospital where all physicians are paid by salary but one at least has company. Many hospitals, on the other hand, want to retain anesthesia as a hospital service, and some now wish to make all services salaried employees of the hospital. Physicians other than anesthesiologists could well take heed of this encroachment on medical practice; if it can be done with anesthesia it can be done with other services.

The public is the least of our problems. An interested surgeon can sell his patients professional anesthesia very easily with a few sincere words. Patients do not object to paying a fee to the anesthesiologist when they understand the arrangement in advance and the service has been properly rendered. This makes for a surgeon-patient-anesthesiologist relationship that is beneficial and necessary to all three for the best results.

At the present time the best trained anesthesiologists are going to the communities that offer the best working conditions. Most of them want to administer anesthesia and not just act as a trouble shooter. Physicians will choose anesthesia in greater numbers only when they see this specialty treated with the same respect as others.

Summary

The majority of the medical profession admit that anesthesia is important and some that it should be administered by a properly trained physician. An attempt has been made to point out the part that the profession must take in bringing about improvement in anesthesia for their patients. The anesthesiologist seeks professional standing equivalent to other physicians in the community and at the present time such localities are attracting these specialists.

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WISCONSIN SURGICAL SOCIETY TO MEET ON APRIL 29

Members of the Wisconsin Surgical Society will gather at Madison on April 29 for a spring meeting. Dr. Kenneth Lemmer, Madison, is in charge of arrangements.

Following operative clinics at the Wisconsin General Hospital from 8 to 10 a. m., the following program will be presented:

"Cystic Disease of the Lung"—William P. Young, M. D.
"The Surgical Treatment of Pulmonary Abscess"—John T. Mendenhall, M. D.
"Mediastinal Tumors"—Anthony R. Curreri, M. D.
"Carcinoma of the Lung"—Joseph W. Gale, M. D.

Noon luncheon, Wisconsin General Hospital

"Repair of Extensor Injuries of the Forearm"—Frederick Bunkfeldt, Jr., M. D., Milwaukee
"Colles' Fracture"—Nathan E. Bear, M. D., Monroe
"Renewed Hope of the Cure of Carcinoma of the Cervix"—Paul F. Doege, M. D., Marshfield
"Vaginal Hysterectomy"—Roger T. Cooksey, M. D., and Samuel B. Harper, M. D., Madison
"Gallbladder Surgery: A Study of the Results of Surgical Treatment in Rock County, Wisconsin"—Thomas J. Snodgrass, M. D., Janesville; Wayne A. Munn, M. D., Janesville; and Thomas H. Flarity, M. D., Beloit

A business meeting will be held at 5 o'clock, and a 6:30 dinner will be served at the Maple Bluff Country Club.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Phisoderm and Hexachlorophene For Disinfection of the Skin

According to Bromley S. Freeman and Thomas K. Young,[1] throughout the surgical services in their hospital during the period April 15 to Aug. 15, 1947, all operative sites were prepared by a ten minute soap scrub, followed by alcohol, ether, and zephiran; hands received the usual ten minute soap scrub followed by a one minute wash in alcohol. During the period April 15 to Aug. 15, 1948, skin and hands were prepared as follows.:

Three per cent hexachlorophene in the sulfonated detergent, phisoderm, was applied to the skin and a lather developed with gauze sponges wet in sterile water; the area was shaved, wiped clean, and again scrubbed for four minutes with the agent; it was then wiped off with a wet sponge and blotted dry with a sterile towel.

In preparing the hands, the subungual spaces were scraped with the tip of the nail file, the hands and arms were thoroughly wet, one 2 cc. shot of detergent was taken in each hand, the hands and arms were washed for one minute and then rinsed completely. The process was then repeated and an anatomic scrub developed with the brush so that every area of the skin received fifteen brush strokes and the nails twenty-five strokes; rinsing then occurred with tap water. The process took two minutes.

During the soap period, the infection rate in 368 operative procedures was 8.2 per cent. During the detergent period, 2.1 per cent in 328 procedures. The entire surgical staff was impressed by the simplicity of the technic, the reduction in time consumed, and the immediate excellent results. There were no evidences of skin reaction in either patients or personnel.

The authors, of course, do not feel that the reduction in incidence of wound infections to one-fourth that in their control series is an absolute indication of the efficacy of the detergent method. I think it a particularly weak point in the study that the controls were patients seen in the preceding year. However, studies of preceding workers have strongly indicated the superiority, from the more purely scientific standpoint, of hexachlorophene to soap in preparation of the hands and skin, and it is therefore good to have this confirming clinical study. phisoderm is a detergent cream composed of sulfonated ether petrolatum, lactic acid, and wool fat cholesterols, and is said to possess active emulsifying, sudsing and dispersing properties with a surface activity about 40 per cent greater than that of soap. Having a pH of 5.5 it is said to preserve the normal acid pH of the skin and to yield no objectionable end products on hydrolysis.—HARRY BECKMAN, M.D.

REFERENCE

1. Freeman, B. S., and Young, T. K.: Clinical study of the use of a synthetic detergent (pH isoderm) combined with hexachlorophene for disinfection of the skin, Surgery 25: 897–901 (June) 1949.

WISCONSIN TRUDEAU SOCIETY TO MEET IN MILWAUKEE

The Wisconsin Trudeau Society will meet in Milwaukee on May 9, in conjunction with the forty-second annual meeting of the Wisconsin Anti-Tuberculosis Association May 9–11. The morning program will be presented at the Milwaukee County General Hospital and will consist of a chest clinic presented by Dr. Einar Daniels and associates of the chest service of Milwaukee County General Hospital. During the afternoon and evening the group will meet in the East Room of the Hotel Schroeder.

The following program will be presented:

2:00 p. m.: "Pathological and Roentgenological Studies of Pulmonary Pathology in Autopsy Material"—W. L. Brosius, M. D., Detroit
2:45 p. m.: "Clinical Application of Pulmonary Function Tests"—Francis B. Landis, M. D., Wood
3:15 p. m.: Discussion of the above presentations
3:30 p. m.: "Late Results of Thoracoplasty According to Type of Pulmonary Tuberculosis"—Douglas A. Gutheil, M. D., Muirdale Sanatorium
4:15 p. m.: Discussion, led by Joseph W. Gale, M. D., Madison
4:30 p. m.: "Chemotherapy Summary"—Roger A. Hemphill, M. D., Wood

A business meeting will be conducted at 4:45 in the afternoon. Following a 6:30 dinner in the East Room, Dr. J. Maxwell Chamberlain of New York will address the assembly on "Segmental Pulmonary Resection."

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Examination of Gastric Fluid

Volume

About 25 cc. of gastric residuum may be withdrawn from the normal stomach after twelve hours' fasting. The volume of gastric residuum obtained before breakfast is quite revealing in the study of peptic ulcers. When the volume is greater than 50 cc., it indicates hypersecretion or obstruction, which may be either spastic or organic. The therapeutic response may be observed by measuring the fasting gastric contents. The study is performed by removing the gastric residuum each night on retiring, then lavaging the stomach and introducing an antacid through the tube. If the volume is not decreased when the residuum is removed the following morning, obstruction undoubtedly persists.

Blood

Occult blood is not as significant as gross blood because trauma in introduction of the tube must be considered. Trauma is seldom great enough to yield gross blood. However, careful introduction of the tube should not yield a positive test for occult blood.

Acidity

The interpretation of gastric hypoacidity or anacidity must be carefully evaluated. Some apparently normal individuals have quantitative and qualitative deficiencies. About 2 per cent of children have no free hydrochloric acid, and the incidence of achlorhydria or hypochlorhydria increases with age, reaching 20 per cent or more in patients past 60 years of age. Hereditary achlorhydria has been proved, and it has been found that achlorhydria was present in some patients with pernicious anemia for several years before the characteristic hematologic changes developed. Apparently healthy relatives of patients with pernicious anemia have absence of free hydrochloric acid.

A state of hypochlorhydria is considered when gastric analysis reveals less than 25 units of free hydrochloric acid. No test revealing achlorhydria should be relied upon without using a good secretory stimulant such as histamine. The usual dose for adults is 0.25 mg. The frequent recommended dose of 0.1 mg. per 10 kg. of body weight is excessive and may cause disagreeable reaction.

Hypoacidity is associated with pernicious anemia, carcinoma of the stomach, chronic (atrophic) gastritis, nutritional disturbances, chronic debilitating conditions, pulmonary tuberculosis, hyperthyroidism, arthritis, and ulcerative colitis.

Hypochlorhydria or achlorhydria frequently has no clinical significance except that it may rule out peptic ulcer or substantiate a diagnosis of pernicious anemia or carcinoma of the stomach. The test for acidity is becoming more important after gastric resection for peptic ulcer since the success of surgical treatment depends upon the complete removal of the acid-secreting portion of the stomach (lesser curvature).

Achylia gastrica designates absence of acid and enzymes and should not be considered synonymous with achlorhydria.

Hyperacidity exists when more than 50 units of free hydrochloric acid is present. Hyperacidity is present in about 5 per cent of normal individuals. About 85 per cent of patients with peptic ulcer have significant hyperacidity. Between 5 and 10 per cent of patients with characteristic symptoms of peptic ulcer have negative roentgenologic findings. About 90 per cent of these patients have hyperacidity. It must be remembered that the presence of hyperacidity does not rule out carcinoma of the stomach. About 10 per cent of chronic gastric ulcers reveal neoplasia. Nearly 20 per cent of patients with gastric carcinoma have normal or increased acidity.

No discussion on examinations of gastric contents is complete without mentioning cultures for tubercle bacilli, which have been discussed in this column previously.

The cytology of gastric fluid will be presented in a future issue.—S. B. PESSIN.

SOCIETY OF OBSTETRICS AND GYNECOLOGY TO MEET IN MILWAUKEE

The Wisconsin Society of Obstetrics and Gynecology will hold its spring meeting at the University Club of Milwaukee on May 5. The session will begin at 9 a. m., and a luncheon will be served at noon.

Guest speaker for the occasion will be Rockwell Levine, M. D., a member of the staff of Michael Reese Hospital, Chicago, whose subject will be "Pregnancy and Diabetes."

THE MEDICAL FORUM

Wisconsin MD's Attend Atomic Medicine Course

Madison, Mar. 31.—Dr. Erwin P. Ludwig, Wausau, represented the State Medical Society at a 5-day course in the medical aspects of atomic warfare at Argonne National Laboratory, Chicago during the last week of March.

Other Wisconsin physicians attending the course were Drs. Edwin C. Albright, Madison, representing the University of Wisconsin medical school; James M. Sullivan, Milwaukee, representing Marquette University school of medicine, and A. L. Van Duser, Madison, for the state board of health.

Get Basic Training

All four were chosen by Governor Oscar Rennebohm and approved by the National Security Resources Board and the Atomic Energy Commission.

DR. E. P. LUDWIG

The men will receive "primary" training in radiation medicine and will return to Wisconsin to outline and conduct a training program in atomic medicine for all physicians, nurses, dentists and allied professional people.

AMA Asks Complete Cooperation on Survey of Doctors' Incomes

Send Out Questionnaires in Late April; AMA Works With Commerce Department

Chicago, Mar. 20.—The Board of Trustees of the American Medical Association is making an urgent request for cooperation from some 125,000 physicians who will be contacted late in April as part of a survey of physicians' incomes.

The survey is being conducted jointly by the bureau of medical economic research of the AMA and the office of business economics of the U. S. Department of Commerce. It is the first full-scale survey of doctor's incomes since 1941.

An analysis of the results will be published by the Department of Commerce next fall. Similar analyses of dentists' and lawyers' incomes have already been printed.

The AMA emphasizes the importance of all doctors filling out the questionnaires, since there is evidence that the national averages in some surveys have been too high because physicians who do not have bookkeepers to fill out questionnaires do not reply in sufficient numbers.

Accurate postwar data is needed to develop better estimates of how much the American people pay to physicians.

Every physician can be assured that the survey has no relation whatever to the operations of the U. S. Bureau of Internal Revenue, the AMA said. The AMA helped design the two forms to be used. Both are to be returned unsigned in franked envelopes.

Forms will be sent to 125,000 physicians in the punch card files of the AMA. All addressing will be done at AMA headquarters. Physicians need have no suspicion about code numbers on the envelopes, because only the AMA will be able to identify physicians. This is for purpose of follow-up letters in the event no reply is received immediately.

Wisconsin's Health Achievements Noted in Congressional Record

SEN. WILEY PRAISES 12-POINT PROGRAM

Washington, D. C., Mar. 21.—The "pioneering vision, industry, energy and resourcefulness" of Wisconsin practitioners was praised by Senator Alexander Wiley, Chippewa Falls, when he placed a complete reprint of Wisconsin's accomplishments under the AMA 12-point program in the Congressional Record of Tuesday, March 21.

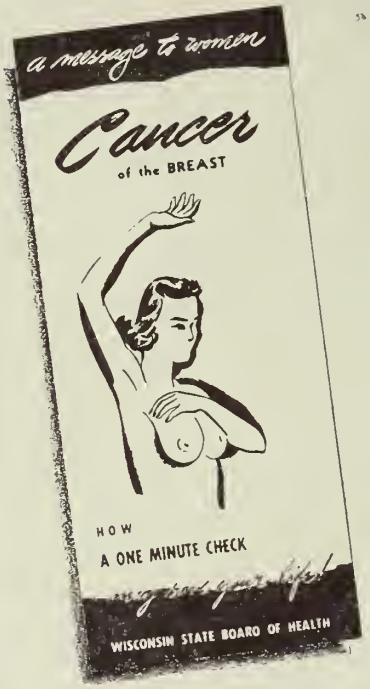
The record of Wisconsin's achievements was taken from the Medical Forum section of the Wisconsin Medical Journal for January, 1950.

Senator Wiley stated that he has continually emphasized that the medical profession of the United States is "more than adequate and competent to meet the health needs of the American people without political nostrums—without socialized medicine."

He said, "it is with deep pride that I note that the State of Wisconsin has pioneered to provide prepaid health care. Nearly one million people in the Badger State are enrolled in various plan."

"Dynamic" Program

Declaring that the Wisconsin medical profession has pioneered "along every single one of the dozen paths recommended by the American Medical Association," Senator Wiley said, "not only is this an excellent commentary on the pioneering vision, the industry, the energy the resourcefulness of Wisconsin practitioners, but it shows that the American Medical Association has not simply set up paper plans but rather that its program is based upon reality, upon active measures which it will dynamically continue."



NEW BREAST CANCER PAMPHLET SENT OUT

Doctors' Aid Sought

Madison, April 19.—As a result of the efforts of the Cancer Committee of the State Medical Society and the Division of Cancer Control of the State Board of Health, a new pamphlet (pictured above) directed to Wisconsin women is being distributed in hopes that more cancer of the breast can be brought to the physician in its early curable stages.

A copy of the pamphlet and a letter explaining its purpose has been sent to all physicians. A supply of the pamphlets for office use and distribution may be obtained by returning an order card enclosed with the letter.

All physicians are urged to make every effort to arrange for the introduction of this pamphlet and its proper medical interpretation to Wisconsin women.

The pamphlet emphasizes two important practices; that periodic self breast examination uncovers tumors early, and that early medical diagnosis and care of such findings should be sought.

AMA Replies to Criticism of Campaign Picture "The Doctor"

Chicago, Mar. 31.—Criticism of the use of the picture, "The Doctor" by Sir Luke Fildes, as part of the national education campaign of the AMA has been answered by campaign director Clem Whitaker.

To Dr. Elbert L. Persons of Duke University School of Medicine, Durham, N. C., Mr. Whitaker wrote the following letter on March 14:

"Doctor Lull let us see a copy of your letter of February 3rd in which you object to use of 'The Doctor' picture on A. M. A. envelopes, and suggested we write you concerning it.

"We agree, of course, that the picture is 'dated', if viewed literally, but on that basis a great many things are 'dated', including the Hippocratic oath, the Bible and the works of Dickens and Shakespeare. Yet in meaning they are still vital and pertinent, even though the langauge is not of our era.

"Similarly, the painting of 'The Doctor' is 'dated'; the physician. the patient and the surroundings have all changed, in outward appearances. But the compassion in that doctor's face—and his concern over his patient—are characteristics of a good doctor today, as they were then, and if modern practitioners ever come to the point where they believe scientific knowledge can replace personal interest in the welfare of those who depend on them for life and healing, then we will have lost one of our most effective arguments against Government—controlled medical practice.

"I am not a doctor, but I have been a doctor's patient, and I think my viewpoint is somewhat typical of that of most patients. When I'm sick, I want *my doctor*, not just any doctor, because my doctor, while he may not be any better than a great many other doctors, is concerned about me, and I have implicit confidence he will do everything in his power to help me.

"We are surrounded by doctors in our work here—very able doctors, too, I am confident—and yet when my partner, Leone Baxter, had a miserable hacking cough a few months back, which gave her a bad time, she flew 2,000 miles back to San Francisco to get treatment from 'her doctor'. Incidentally, he cured her difficulty in short order—and I imagine her peace of mind, which came from faith in her doctor, had as much to do with the cure as his knowledge of medicine.

"The Fildes painting of 'The Doctor' even though it is old-

(See page 306c, col. 2)

MR. EWING vs. DR. LULL

Mr. Ewing: "Our campaign plan is to educate each of the 3,000 Democratic precinct committeemen and women in all details of the National Health Insurance Plan. They will explain it to the People."

Dr. Lull: "We will have to carry on this fight until someone is licked. It is false to ourselves and false to the medical profession to take the attitude that there is no need to continue an active campaign."

Sargent on Active Duty for Medical-Defense Work

Milwaukee, Mar. 27—Dr. James C. Sargent, chairman of the AMA Council on National Emergency Medical Service, spent the week of March 27 on active duty with the Navy for instruction in Medical Aspects of Special Weapons and Radioactive Isotopes at Bethesda, Maryland.

Dr. Sargent has also accepted an invitation to attend the Joint Civilian Orientation Conference established by the Secretary of Defense to make a preliminary survey of several defense problems.

The medical profession's role in a civilian defense program will be discussed at AMA headquarters on Saturday, May 6, according to Dr. Sargent. Representatives of state medical associations have been invited to the meeting where discussions are planned on various civilian defense aspects of atomic, chemical and psychological warfare, and a review of the programs already developed in several states to cope with disasters of all types.

CARL N. JACOBS

Jacobs Heads Chamber of Commerce Social Security Group

Madison, Feb. 25.—Carl N. Jacobs, president of the Hardware Mutual Casualty Company of Stevens Point is the newly appointed chairman of the Wisconsin State Chamber of Commerce's Social Security Committee.

He succeeds J. L. Whittet, assistant controller of Ed Schuster & Company of Milwaukee, who has been the committee leader for the past two years.

P. M. Chiuminatto, secretary-treasurer of the Hoberg Paper Mills of Green Bay and the committee's first chairman, is now a member of the State Chamber's Board of Directors. Both Whittet and Chiuminatto continue to serve as members of the committee.

Medical Society Represented

The Committee has five new members, including C. E. Goodell, Airkem Sales and Service, Milwaukee; Francis W. Kerscher, Frank J. Kerscher Company, Manitowoc; W. F. Kurfess, Joseph T. Ryerson & Son, Milwaukee; Harold E. Scherer, Monroe Clinic, Monroe; and L. R. Wheeler, Asociated Hospital Service, Milwaukee.

Other members of the committee include Charles H. Crownhart, State Medical Society; William KasaKaitas, Wisconsin Farm Bureau Federation; Arthur P. Miles, University of Wisconsin; and Marvin Verhulst, Wisconsin Canners Association, all of Madison; L. A. Markham, Chevrolet–Janesville Division of General Motors, Janesville; and S. L. Horman, Time Insurance Company; K. B. Howell, Kendall Corporation; Frank Hughes, Mutual Benefit Life Insurance Company; C. C. Klocksin, Northwestern Mutual Life Insurance Company, and B. A. Krawczyk, Allis Chalmers Manufacturing Company, all of Milwaukee.

Recent efforts of the committee have been devoted to policy recommendations on HR 6000 (social security revision bill) now before the U. S. Senate.

AMA REPLIES—

(From page 306b)

fashioned, portrays something which is beyond value to the medical profession. To the public, let me assure you, it makes sense to say 'Keep Politics Out Of This Picture', and the best evidence of the picture's effectiveness is the mighty effort our opponents have made to discredit it. If it weren't effective, the soclializers would have ignored it, instead of writing thousands of words to complain about it.

"Miss Baxter and I were interviewed recently by a medical writer for one of the great National magazines. In the course of the interview, he said that when we first started to use 'The Doctor' picture, he thought it was a mistake—that it harked back to an era that was gone. But he concluded by saying he felt it had become a tremendously effective symbol. And thousands of doctors, who are displaying the picture in their offices, think so, too.

"Please know that we don't expect unanimity of opinion on all phases of the A.M.A. program, and that we respect your right to dissent, but we feel 'The Doctor' picture has served medicine's cause well. Perhaps it is on the sentimental side, but a little sentiment, in a fight like this, is good medicine. It helps to counteract some of the cheap emotionalism which our opponents are using against us.

" 'The Doctor' isn't just an outdated painting. It is a vivid portrayal of the vitally important physician–patient relationship which has made doctors something more than medical technicians. And that relationship is out-dated only in countries which have adopted socialized medicine.

Blue Shield Plans to Set Up New Agency

Chicago, March 10.—After approval by a majority of the Blue Shield Plans, arrangements are under way for establishment of an agency to handle uniform medical prepayment insurance to national employers.

The proposed agency — Associated Medical Care Insurance Company — will provide medical-surgical coverage paralleling the hospital coverage to be made available through Blue Cross.

Plans for a combined enrollment agency were first presented at a Blue Cross–Blue Shield conference in October 1948. The proposal was approved by Blue Cross, but Blue Shield delayed approval until the AMA could act on the matter.

AVOID THE CATASTROPHE LOSS!

We are all concerned about being disabled or hospitalized for an extended period of time. Time coverages are designed to help with the minor losses, and to assume the major burden of the catastrophe loss.

Our new Hospital–Surgical plan is the only real answer to the tremendous expense of an extended hospital confinement:

$10.00 a day room and board benefit

50% of all miscellaneous hospital charges up to $100.00, and

100% of all such charges thereafter—**unlimited**

$200.00 maximum surgical benefit

World wide coverage

The Time Insurance Company

213 W Wisconsin Ave.

Milwaukee 3, Wis.

NINE-MAN BOARD RUNS STATE'S LARGEST DEPARTMENT

PUBLIC WELFARE BOARD STRESSES BUILDING PROGRAM, PREVENTIVE WORK

Madison, Mar. 2.—The state welfare department's $13,000,000 building program will "go forward as fast as possible," according to the new department director, Mr. John W. Tramburg.

New construction is one of the major projects of the state board of public welfare for the present biennium.

Mr. Tramburg emphasized, however, that he will place a lot of stress on preventive programs designed to eliminate the need for continual expansion of plant facilities.

Huge Budget

"The nation is spending a terrific amount to run institutions," he said. "Preventive work could keep down institution populations."

The newly reorganized state Department of Public Welfare operates under a nine-member policy making board with authority to spend about $100,000,000 during this biennium.

The nine citizens appointed to the new board by Governor Oscar Rennebohm represent a wide variety of geographic, professional and lay interest.

Already several accomplishments of the board indicate the trend of thinking in the department:

1. A new director was selected and has taken office.
2. It approved the establishment of a medium security prison to relieve congestion at Waupun and provide greater opportunity for rehabilitation.
3. It approved and assigned first construction priority to three new buildings for the Southern Colony and Training School at Union Grove.
4. It has approved a plan for the integration of the work of the Psychiatric Institute of the University of Wisconsin medical school and the mental hygiene division of the state department of public welfare.

They have also invited division, department and bureau heads to appear before them to explain their

Members of the Board

Mrs. C. R. Beck, West Allis. Member of the Wisconsin Committee on Children and Youth. (Secretary)

Mrs. Harrison L. Garner, Madison. Member of the old Board of Public Welfare.

Earl M. Hale, Eau Claire. Owner of a book publishing company.

Leo Jelinske, Shawano. Director of the Shawano county welfare department.

Mrs. Karl Kleinpell, Cassville. President of the Wisconsin Federation of Women's Clubs.

Harold W. Story, Milwaukee. Corporation counsel for the Allis-Chalmers Mfg. Co. (Vice-chairman of the board).

Dr. W. D. Stovall, Madison. Director of the state laboratory of hygiene (Board chairman).

Dr. William Studley, Shorewood. Director of the Shorewood hospital, a private sanitorium

Ralph Uihlein, Milwaukee. Chairman of the social planning committee of the Community Welfare Council of Milwaukee County.

Seated, left to right: Leo Jelinske, Mrs. Karl Kleinpell, Mrs. C. R. Beck, Dr. William Stovall. Standing, left to right: Ralph Uihlein, Dr. William Studley, Mrs. H. L. Garner, Earl M. Hale, Harold W. Story.

work, and have demonstrated their willingness to hear anyone who has an interest in any phase of public welfare.

The board meets every two weeks, and all members give considerable time to committee work. One committee is considering about 20 applications for the position of director of the division of child welfare and youth services.

Another committee is soliciting applications for the position of director of the division of mental hygiene, which has been vacant since Dr. Walter J. Urben resigned two years ago to become superintendent of Mendota State Hospital.

JOHN W. TRAMBURG

Tramburg Named to Public Welfare Post

Madison, Mar. 2.—With an announcement that he believes in strong preventive and protective programs in mental health and juvenile delinquency, thirty-seven-year-old John W. Tramburg took over the operation of the state's largest department on March 1

The new director of the State Department of Public Welfare succeeds Allan W. Bayley, former director, who has been named deputy director under Tramburg. Bayley has been acting director since the department was reorganized last fall under legislative orders.

Tramburg was welfare director of the District of Columbia for nearly two years before coming to Wisconsin. He was born and reared in Wisconsin and graduated from Whitewater State Teachers College.

MILWAUKEE DOCTORS OPPOSE HEALTH PLAN

Milwaukee, March 2—The Board of Directors of the Medical Society of Milwaukee County recently acted to express opposition to national health insurance legislation. This raises to 129 the number of organizations in Wisconsin on record against compulsory health insurance.

The resolution of the Milwaukee County Society follows:

"WHEREAS, The American people have today the highest standards of health and of medical and dental care this nation or any other nation, has ever seen; and

"WHEREAS, it has been shown that these levels of American health and medical care standards are rising, year after year, under a system of free medicine, and,

"WHEREAS, the voluntary medical care and hospitalization prepayment plans in this country have demonstrated their effectivenes in placing the costs of illness under sound actuarial programs, and are growing in coverage and effectiveness every year; and,

"WHEREAS, the experience in countries having governmentally controlled compulsory health insurance plans has shown that such schemes fall short of theoretical expectations, and have in many particulars caused severe deterioration in the health standards of the general public in those countries; and

"WHEREAS, there is danger that a comparable national compulsory health insurance scheme might be adopted in this country, to the detriment of the health standards of the American people;

"Therefore, be it resolved, That the Medical Society of Milwaukee County go on record as being in firm opposition to any legislation which would institute national compulsory health insurance in this country, or any other legislation which would result in government overshadowing the spirit of free medicine in the United States, and

"Be it further resolved, That the Medical Society of Milwaukee County communicate its opposition to national compulsory health insurance legislation to the Wisconsin Congressional delegation."

CANCER GRANTS TO WISCONSIN

Madison, Mar. 13.—More than $36,000 of a recent $863,000 public health service grant for cancer research was awarded to the University of Wisconsin.

Recipients of the grants were Drs. Van R. Potter, nature of biochemical synthesis connected with growth; Roland K. Meyer and W. H. McShan, enzymes in estrogen-induced pituitary hyperplasias; James A. Miller and Harold P. Rusch, formation and inhibition of liver cancers, and Philip P. Cohen, research on soluble proteins of normal and neoplastic tissues.

New Union Contract Pays Medical Bills

Milwaukee, Feb. 17—A new union contract to help pay doctor bills of fur and leather workers at the J. Greenebaum Tanning Co. was announced recently.

A. J. Tomlinson, president of the International Fur and Leather Workers, (CIO) leather division, said that the new contract provided for payment of some 70 per cent of doctor bills for workers and their dependents, up to $150 per person for each illness.

The medical fee insurance is in addition to life, accident, hospital and surgical care insurance already in force.

Tomlinson said that most doctors charged $3 for an office call or $4 for a home call. The new insurance plan will pay all but $1 of either fee for workers, their wives and their children under 18.

The contract covers about 1,450 workers in Milwaukee and Chicago plants.

PBS
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221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions
References furnished on request.

Hunt and Bosone Bills Aim for National Voluntary Health Plans

Washington, D. C., Mar. 7.—Although most observers concede that no health insurance legislation will be passed during the present session of Congress, a variety of proposed laws have been submitted. Several are creating widespread discussion:

Sen. Lester C. Hunt, (S. 2940), Wyoming, proposes to consolidate the health activities of the government in a Department of Health under a secretary who is a professional health worker with experience as a practicing doctor or dentist, and a voluntary health insurance program to be administered by a 5-man national health insurance board.

Any individual or family with less than $5,000 yearly gross income could apply for coverage. The amount of the premium to be paid by the covered person would be determined by the board.

AMA Approves in Part

Benefits would be paid (after the first $5) for medical, dental, hospital, nursing, lab, ambulance and other services. Hospital benefits are limited to 60 days a year; 30 days for TB or mental diseases. No mention is made of the manner in which medical personnel will be paid for services.

The AMA reported on March 3, 1950 that it agrees with Sen. Hunt on a Department of Health, but with a physician as secretary. It opposes his insurance program because it is administratively complex and vague, federal control of medical care would result, it would eliminate most physician-sponsored prepay plans and those of commercial insurance companies, and no estimate of cost to either subscriber or taxpayer is given.

Rep. (Mrs.) Reva Beck Bosone, (HR. 6766), Utah, suggests a $50–deductible scheme. A 3 per cent pay roll deduction from all wage earners covered by the social security law would entitle them to payment of all medical services in excess of the first $50 and dental bills in excess of the first $25 in any year. Up to 1 per cent of the national pay roll could be taken from the U. S. Treasury to cover any additional financing.

Medical services could be rendered only by medical personnel certified as participants by the federal security administrator. Medical services would include physicians' care, nursing, hospital (for 60 days; 30 days TB or mental), laboratory, specialist, expensive drugs and appliances.

Dependents would be covered. Free choice among participating doctors is assured. The federal security administrator would prescribe standards for all medical personnel, and health service fee schedules would be fixed by a 15-man board selected by the state medical societies.

Rep. Kenneth B. Keating, (HR. 6819 and HR. 6727), New York, introduced two bills; one to permit 60% to 90% deduction of nonprofit voluntary health insurance premiums directly from their income tax returns, the other to permit deduction of either profit or nonprofit health insurance plan preminums for the same purpose.

DEMAND HEARINGS ON HEALTH BILLS

Washington, D. C., Feb. 17—Public hearings were demanded recently by six Republican authors of voluntary health insurance bills.

Dr. Joseph S. Lawrence, director of the American Medical Association Washington office, reported that the legislative coordination committee of the American Medical Association will furnish a list of witnesses in the event hearings are scheduled.

The voluntary health insurance bills in question are H.R. 4918 through H.R. 4924. These bills would make use of present voluntary health plans such as Blue Cross–Blue Shield, and all commercial insurance company plans, and in addition many new plans could be started by consumer controlled groups to provide coverage.

The plans would be financed by a 3 per cent pay roll tax on incomes up to $5,000. Federal and state governments would pay any difference between the cost of the service and the amount of contributions.

Progress of Voluntary Prepaid Plans

A total of more than $161,000,000 was paid to hospitals by the 90 Blue Cross plans in the United States for the care of Blue Cross members during the first six months of 1949. This sum represents the largest percentage of income that the plans have paid for member's care in their history. Of the total income, 87.6% went directly to hospitals for services rendered to members and 9.1% went for operating expense.

* * *

Nearly 100,000 new members joined the Health Insurance Plan of Great New York during 1949. The corporation, which began operation on March 1, 1947, provides complete medical, surgical, maternity and specialist care on a prepayment basis to a membership now totaling more than 230,000. Membership is open to employee groups of 10 or more.

* * *

The Rhode Island State Medical Society is setting up the Rhode Island Physician's Service in cooperation with the Hospital Service Corporation of Rhode Island to provide another means of insuring the public with voluntary prepaid care. The surgical phase of the new program duplicates the present Rhode Island Plan (similar to the Wisconsin Plan) in operation under the Society's auspices and underwritten by private insurance companies.

* * *

Effective April 1, 1950 the Medical Service Association of Pennsylvania is expanding its Blue Shield coverage to raise the surgical fee schedule from a limit of $150 to $200; payment for 70 days of medical treatment for in-hospital patients; $10 for one bedside consultation per admission, and 21 home or office visits per contract year. There is no increase in subscription rates.

* * *

The Blue Cross Plan of Wisconsin reports a total enrollment of 760,114 persons as of January 31, 1950. More than 630,000 are covered by group policies and 140,000 by individual policies. Total benefits paid by the Wisconsin Blue Cross in the last 10 years total more than $21,000,000.

HERE'S WHERE THE MONEY GOES

Madison, Feb. 25.—The drive to reduce federal spending has been renewed by the Wisconsin State Chamber of Commerce as a result of President Truman's estimate of the 1950–51 federal budget.

It will cost Wisconsin taxpayers approximately $891,219,000 for federal government expenses in 1950–51 under the Truman budget, according to the Chamber of Commerce. This compares with a total of $228,005,000 in local and state taxes on property and individual and corporate incomes levied or collected in Wisconsin in 1949.

In other words, according to the Chamber, for every $1.00 in state and local property and income taxes paid by Wisconsin taxpayers in 1949, another $3.16 is required in federal taxes to meet Wisconsin's share of federal spending.

The President's $42.4 billion budget for 1950–51 does not tell the whole story, says the Chamber, since it does not include social security programs financed by payroll taxes dedicated to these purposes which do not appear in the budget proper.

The costs and comparisons for each county are shown in the following table at the right:

COST TO WISCONSIN TAXPAYERS OF 1950–51 FEDERAL EXPENDITURES AS PROPOSED BY PRESIDENT TRUMAN*

County	Share of Cost of Proposed 1950–51 Federal Expenditures (000 omitted)	Property & State Income Taxes in Wisconsin in 1949 (000 omitted)	For Each Dollar Paid in State & Local Property & Income Taxes, Federal Expenditures Are Equal to:	County	Share of Cost of Proposed 1950–51 Federal Expenditures (000 omitted)	Property & State Income Taxes in Wisconsin in 1949 (000 omitted)	For Each Dollar Paid in State & Local Property & Income Taxes, Federal Expenditures Are Equal to:
STATE TOTAL	$891,219	$282,005	$3.16				
Adams	508	405	1.25	Marathon	$ 16,862	$ 5,508	$3.06
Ashland	3,137	1,015	3.09	Marinette	6,675	2,323	2.87
Barron	4,171	2,105	1.98	Marquette	669	501	1.34
Bayfield	1,025	704	1.46	Milwaukee	351,853	99,810	3.53
Brown	27,387	7,102	3.86	Monroe	2,959	1,617	1.83
Buffalo	1,319	1,040	1.27	Oconto	2,513	1,317	1.91
Burnett	695	449	1.55	Oneida	4,625	1,565	2.96
Calumet	3,101	1,143	2.71	Outagamie	21,264	5,750	3.70
Chippewa	5,855	2,213	2.65	Ozaukee	7,210	1,661	4.34
Clark	3,315	2,048	1.62	Pepin	704	444	1.58
Columbia	5,713	2,107	2.71	Pierce	2,317	1,286	1.80
Crawford	1,533	1,112	1.38	Polk	2,353	1,537	1.53
Dane	42,636	13,880	3.07	Portage	5,347	1,852	2.89
Dodge	10,169	4,232	2.40	Price	1,872	807	2.32
Door	3,137	1,328	2.36	Racine	40,764	9,586	4.25
Douglas	7,968	3,247	2.45	Richland	2,094	1,348	1.55
Dunn	2,959	1,511	1.96	Rock	32,663	8,277	3.95
Eau Claire	14,242	4,161	3.42	Rusk	1,702	843	2.02
Florence	241	161	1.49	St. Croix	3,351	1,485	2.26
Fond du Lac	15,882	4,858	3.27	Sauk	5,026	2,251	2.23
Forest	1,239	445	2.78	Sawyer	882	469	1.88
Grant	5,713	3,049	1.87	Shawano	3,387	1,740	1.95
Green	5,445	1,940	2.81	Sheboygan	21,897	6,947	3.15
Green Lake	2,487	976	2.55	Taylor	1,881	1,060	1.77
Iowa	2,210	1,337	1.65	Trempealeau	2,255	1,377	1.64
Iron	1,319	612	2.16	Vernon	2,451	2,140	1.15
Jackson	1,604	1,025	1.56	Vilas	1,497	618	2.42
Jefferson	9,385	3,130	3.00	Walworth	8,315	3,190	2.61
Juneau	1,720	1,025	1.68	Washburn	1,123	527	2.13
Kenosha	23,127	6,715	3.44	Washington	7,174	2,172	3.30
Kewaunee	2,059	939	2.19	Waukesha	20,908	5,913	3.54
La Crosse	17,566	5,303	3.31	Waupaca	5,321	2,184	2.44
Lafayette	2,709	1,527	1.77	Waushara	1,230	712	1.73
Langlade	2,941	1,208	2.43	Winnebago	27,601	7,519	3.67
Lincoln	4,019	1,524	2.64	Wood	13,761	4,565	3.01
Manitowoc	20,177	5,528	3.65				

Prepared by the Wisconsin State Chamber of Commerce, January 11, 1950.

*Estimate of total state share of federal expenditures shown in column 1 is based on a formula which apportions federal taxes according to individual income tax collections, state income and population. Estimate of county shares of state total is based on a formula whose factors are individual and corporate income taxes and retail sales.

Democratic Senator Urges Doctors to Fight CHI

St. Louis, Mo., Feb. 21—A warning that the outcome of next fall's elections will determine whether the American doctor will "remain free or become a slave," was sounded by Dr. R. B. Robins, Democratic National Committeeman from Camden, Ark., at the annual meeting of the American Academy of General Practice.

He urged family doctors to support the fight against compulsory health insurance and to "elect senators and representatives who have the courage to stand against any compromise of American principles."

The AAGP delegates also heard Harold J. Gallagher of New York, president of the American Bar Association, say that the threat of socialized medicine should convince attorneys that their profession may be next.

Gundersen is Chairman of Executive Committee of Board of Trustees

Chicago, Mar. 20.—The Board of Trustees of the American Medical Association has appointed Dr. Gunnar Gundersen, La Crosse, as chairman of the Executive Committee of the Board.

He succeeds Dr. James R. Miller, Hartford, Connecticut, who has resigned as a member and chairman of the Executive Committee because of ill health.

Gavin Reappointed to State Board of Health

Madison, Mar. 20.—Dr. Stephen E. Gavin, Fond du Lac, chaiman emeritus of the Council of the State Medical Society, has been reappointed to the State Board of Health. He has been a member of the board since April, 1943.

Seek to Reduce VA Care of Non-Service Cases

Washington, D. C., March. 7.—The current economy campaign of the Veterans Administration is giving it an opportunity to start solving a long-standing problem—the treatment of veterans whose injuries and illnesses are not service-connected.

Up to now a high percentage of VA patients have been in this category—often times as high as 65 per cent. Under the law, VA is "permitted" to treat such patients if beds are available. In practice, according to Dr. J. S. Lawrence, director of the AMA Washington office, the beds have been made available.

Important VA officials have complained in private about this practice, says Dr. Lawrence, but have not had much success in changing it.

COMMENTS FROM THE WISCONSIN PRESS

South Milwaukee Voice, March 2, 1950—"The perennial seekers after 'something for nothing'—that strange, illusory philosophy of government which seems to have captured the fancy of a formerly industrious and ambitious American public — should have heard a recent speech in Milwaukee by Cecil Palmer, British author, journalist and individualist.

"Government control," he stated, "has 'revolutionized' the status of the doctor and has 'destroyed the relationship between doctor and patient.' He said government orders have required doctors to make complete reports —hitherto confidential, from time immemorial—on all medical cases for the government."

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Dodgeville Chronicle, Feb. 16, 1950—"What the American must understand, however, is that while each of these proposals—Federal invasion of banking, Federal invasion of power and socialized medicine—is promoted as if it were a single reform unrelated to all the others, the simple fact is that each is intended to liquidate some sector of the private enterprise system and expand the area of socialism."

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Jefferson County Union, Fort Atkinson, Feb. 16, 1950—"The Oregon Voter recently published an excerpt from a letter written by a woman in England. In a section dealing with the Labor government's 'free' medical scheme, she says: 'People do have to wait for beds in hospitals and it is all very difficult. Nurses are short and of course doctors are terribly, terribly overworked . . . People run to the doctor for colds and the finger ache. When someone is really almost dying the doctor cannot give as much attention as he should since he is so rushed . . . The working classes cannot see that indirectly they pay as long as they live, through the nose. For this health scheme they will pay always; nothing is free ever."

* * *

The Marinette Eagle Star, Feb. 22, 1950—"Fast-talking Andrew Biemiller, the former Socialist who is now a Democratic Congressman from a Milwaukee district, took part in a panel discussion on compulsory health insurance Sunday and as usual twisted things to suit himself.

"Medical men aren't opposed to the social security program as it now exists, either, though the efficacy of the program is disputed. But it doesn't fit into the debate on compulsory health insurance and the reasons why medical men oppose the latter. Fast-talking Mr. Biemiller knows that, but he prefers to confuse the issue to make his point."

Rep. Smith Tells Racine Labor Paper He's Opposed to Compulsory Health Schemes

Racine, Mar. 27.—Congressman Lawrence H. Smith, (R., 1st District) Racine, recently expressed his opposition to compulsory health insurance schemes in a letter to the editor of *Racine Labor.*

Congressman's Smith's letter replied to an article in the Racine newspaper which expressed the hope that Rep. Smith "wouldn't get too busy with the groups fighting health insurance."

Rep. Smith wrote, in part:

"Very frankly, I am not in favor of COMPULSORY health insurance schemes. And if my mail is any evidence of public opinion, the majority of people in my district are opposed to it. The labor leaders say that the working people will get free medical service and hospitalization, free social security, free everything. This is a rank political promise, a fraud on the public. Be honest—tell them they pay for all such services with money Uncle Sam takes from them."

Rep. Smith said he believes that "our men, women and children can solve their own probelms . . . they are coming to realize that in a free society the individual must pay his own way; that there is no such thing as Santa Claus or a free ride; that you don't get something for nothing."

Science Foundation Wins Approval of Both Houses

Chicago, March 6—One more step toward creation of a National Science Foundation was taken last week in Washington. The House voted 247 to 125 for creation of a foundation which would conduct research and award scholarships for study in scientific fields.

The American Medical Association has advocated such a foundation for a long time. It is point 2 of the American Medical Association's 12 point program.

A similar bill already has passed the Senate, but differences will have to be ironed out. Under the measure, a 24 member board would be set up to serve as a federal clearing house for all scientific and technical research programs conducted by the government and private research groups

DOCTORS URGED TO USE CANCER LIBRARY

Madison, Mar. 15.—The medical and scientific library of the American Cancer Society, 47 Beaver Street, New York 4, N. Y., has a package lending library of reprints on cancer covering the majority of articles published in the last ten years.

This service is now available to doctors and research workers upon request. The cancer society asks that requests be as specific as possible and that general requests be avoided. Materials may be kept for two weeks.

Half U. S. Families Have Less Than $3,500 Income

Washington, D. C., Feb. 25.—The United States Department of Commerce has released a study of 1947 incomes of the people in the U. S.

The study shows the income of 37,000,000 families and 8,000,000 individuals in families living in both rural and urban areas.

The Department of Commerce reports that 55.3% of the families in the urban areas of 50,000 to 249,999 population had incomes less than $3,500 annually; while for the total of all urban and rural families the percentage was 60.7.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

A pamphlet, "Brief on BCG," prepared by Dr. Samuel Rosenthal and published by the Research Foundation, has recently come to our attention. It appears that the information in this pamphlet is of sufficient significance to bring a summary to your attention.

The use of BCG is gradually becoming accepted as an integral part of a tuberculosis control program by international, national, state, and local agencies. Its very gradual acceptance in Wisconsin, after an interval of many years of use elsewhere, speaks well for the caution that is exercised for safety and efficacy before a product is offered to our people. A brief review of evaluations made on the basis of reported observations indicates quite clearly that BCG is safe and that it offers protection which is acknowledged as not complete but which is definitely of value.

I. International

A. The first international BCG Congress held at Paris and Lille, France, in June 1948 passed a resolution which in part states:

1. That the study of more than ten million BCG vaccinations all over the world for twenty-five years confirms the absolute innocuousness of BCG vaccination in man.

2. That BCG is the most efficacious means of prevention against tuberculosis.

3. That BCG vaccination of all newborn children is necessary but that BCG vaccination of anergic adolescent and young adults particularly exposed to tuberculosis infections, that is, apprentices, students, medical personnel, paramedical employees, recruits, etc., is of primordial importance.

B. The Chronicle of the World Health Organization, in the April 1948 issue, calls attention to the fact that the World Health Organization has gone on record as recommending BCG vaccinations in the devastated areas of the world and has appropriated $4,000,000 to carry out this work.

C. In Europe, BCG has been so widely accepted by the medical profession and general population that throughout the Scandinavian countries and France, Hungary, Rumania, Greece, and Russia significant parts of the population have been vaccinated. In selected groups vaccination has become obligatory.

D. In Asia, Brigadier General Sams reports that thirty-one million persons have received BCG immunization in Japan as a result of a tuberculosis control program inaugurated by the Supreme Command of the Allied Powers.

E. In Africa and South America more than a million vaccinations have been offered.

II. National

A. At a meeting of the consultants to the United States Public Health Service held in New York City on March 8, 1948, it was recommended that:

1. The Public Health Service participate directly in the promotion of special studies among exposed groups such as: (*a*) contacts of open cases; (*b*) medical and nursing personnel; (*c*) hospitals, sanatoria, and laboratory personnel; and, (*d*) inmates of penal and mental institutions.

2. Controlled studies with trained personnel be developed with state, territorial, and local health agencies, in good sized population groups where the prevalence of tuberculosis is great.

3. State and local health departments assist in the development of large scale trial immunizations of BCG in the general population in a number of metropolitan areas, whenever possible in conjunction with community x-ray surveys.

B. The American Trudeau Society in January 1948 issued the following summary on BCG. In the light of present knowledge, vaccination of the following more vulnerable groups of individuals is recommended, provided they do not react to adequate tuberculin tests:

1. Doctors, medical students, and nurses who are exposed to infectious tuberculosis.

2. All hospital and laboratory personnel whose work exposed them to contact with the bacillus of tuberculosis.

3. Individuals who are unavoidably exposed to infectious tuberculosis in the home.

4. Patients and employees of mental hospitals, prisons, and other custodial institutions in whom the incidence of tuberculosis is known to be high.

5. Children and certain adults considered to have inferior resistance and living in communities in which the tuberculosis mortality rate is unusually high.

C. In the United States there are many states using BCG for medical and nursing students, hospital and laboratory personnel, children, and certain adults living in communities where the tuberculosis mortality rate is high, and in institutions for feeble-minded persons and those with mental disease. The Tice Laboratory, Research Foundation is supplying BCG vaccine to California, Colorado, Georgia, Indiana, Maine, Massachusetts, Michigan, Minnesota, New Mexico, North Carolina, Ohio, Vermont, Washington, and Wisconsin. The states of New York and Pennsylvania have a BCG program and produce their own vaccine.

(Continued on page 329)

Wisconsin Anesthesia Study Commission

Of the Wisconsin Society of Anesthesiologists

Editor—LUCIEN E. MORRIS, M. D., Madison*

Thoughtful physicians realize that safety in anesthesia depends largely upon the degree of watchful care and judgment exhibited by the administrator of an anesthetic. The ease and rapidity with which accidents may occur dictates the necessity for the anesthetist to maintain at all times close contact with the patient and a constant awareness of the instant to instant kaleidoscopic changes in physiology. Recognition of conditions deleterious to the well being of the patient leads to correction of the difficulty and reduction in the incidence of morbidity and mortality which otherwise obtains.

Experience in the recognition and treatment of difficulties builds judgment in each individual. However, the building of individual experience is a long procedure, and sometimes costly. Whenever possible, particularly when patient well being is at stake, we should learn from the experience and mistakes of others. It therefore seems desirable to submit the details of difficulties, fatalities, and puzzling cases to a professional committee for study, with the object of bringing selected cases to the attention of other physicians in the hope that such reports may possibly decrease the incidence of similar difficulties elsewhere. The Wisconsin Anesthesia Study Commission has initiated this type of evaluation on a voluntary basis and with maintenance of anonymity of contributors in individual submitted cases. Your participation is invited.

CASE 9.— A 59 year old white male was admitted to the hospital with the chief complaint of hematuria and pressure in the right flank. Physical examination revealed arteriosclerotic and hypertensive heart disease. Cystoscopy showed carcinoma of the floor of the bladder involving the ureteral orifices. Intravenous pyelograms showed no function on the right and but poor function on the left. The nonprotein nitrogen level was 120 mg. A left nephrostomy was, therefore, performed with the patient under nitrous oxide-ether anesthesia with semi-closed technic. Following this, his condition seemed to improve, the nonprotein nitrogen level falling to 71 on the first postoperative day. About a week later, with the nonprotein nitrogen at essentially the same level, it was proposed to perform a right nephrostomy. Preanesthetic medication was scopolamine, 1/200 grain. The blood pressure taken in the operating room before anesthesia was 130/100, pulse rate 104, and respiratory rate 20. Induction of anesthesia was begun with semi-closed technic, nitrous oxide-oxygen, and ether was added gradually. There was a slight period of excitement, during which he seemed to resist the added ether concentration. But seven or eight minutes after the beginning of the anesthetic he tolerated the ether concentration very well. There was then a one minute period of pharyngeal obstruction. The obstruction was apparently corrected by changing the position of the mandible. Exchange had been increased by this maneuver, and during the following one minute respirations seemed more forceful, slightly more rapid, and bordered on hyperventilation. Two minutes later respirations suddenly ceased and the ether was turned off. Almost simultaneously the eyes opened and the pupils were seen to be widely dilated. Both corneal and light reflexes were absent. No pulse was felt at that moment. The mask was removed from the face, a pharyngeal airway was inserted, ether removed from the system, and oxygen given by artificial ventilation. After a few seconds the radial pulse was palpated at a rate of 80. Color had been pale and slightly cyanotic during this time but improved rapidly until his lips and earlobes became pink. Four minutes later blood pressure was 170/120 and pulse rate was 88. Plane of anesthesia was lightened and maintenance continued with nitrous oxide-oxygen and very small amounts of ether. He was turned to lateral position with kidney rest up, and an intravenous infusion of 5 per cent glucose in water was begun slowly. The surgical incision was made approximately twenty-five minutes after the beginning of the anesthetic and it was noted that the blood appeared dark. Ventilation with oxygen was again performed and the color was thereby improved. Blood pressure gradually fell and remained between 110 and 120 systolic throughout the remainder of the operation with the pulse gradually rising to 120. Operation was completed and the patient was conscious upon his return to the ward. At that time the blood pressure was 120/80, pulse rate 104 and respiratory rate 24.

Comment of the Anesthetist

My first impression was that this patient was holding his breath because of the high ether concentration, and the ether was therefore turned off at once. However, respirations did not resume and the appearance of the suddenly opened eyes and disappearance of temporal pulse was evidence to the fact that he was deeply anesthetized and in difficulty. I am not certain whether his heart had stopped, although hasty palpation of the wrist and precordium revealed no pulsation. The possibility remains that some heart action could have been so faint as to have been missed under stress of the circumstances. I feel that this man, who was in poor condition, had rapid saturation and relative overdosage of brain and myocardium to provide respiratory arrest and possibly cardiac arrest. In view of the minute amounts of agent required to maintain anesthesia for the following hour, it would seem that I overdosed a very susceptible patient. The possibility of a greater degree of pharyngeal obstruction than I recognized deserves consideration, and could explain his collapse secondary to severe hypoxia in a feeble individual.

(Continued on page 339)

* Present Address: Division of Anesthesiology, Department of Surgery, College of Medicine, State University of Iowa, Iowa City, Iowa.

. . . . THE PRESIDENT'S PAGE . . . .

Mid-Year Examination

MR. PRESIDENT, what has been accomplished since you took office in October 1949? To this, Mr. Dues–Paying–Member, I can reply that your State Medical Society has continued the excellent program of your Past President, Doctor Karl H. Doege, and brought the projects of his year nearer to completion.

The recommendations of the Committee on Mental Hygiene will bear fruit this year, with new buildings going up at Mendota and Winnebago to provide improved facilities for the care of the unfortunate. Along with this brick and mortar improvement is a most timely training program for personnel and advisory aid from state hospitals to county institutions.

The Committee on Group Insurance has carried out studies with the aim of making available a sickness and accident policy to all members of the State Medical Society. Seven of the more than 100 insurance companies writing under the approval of the State Insurance Commission have submitted bids, and the Committee is seeking to determine which will best meet the needs of the members.

To the Interim Committee, while Doctor Doege was its chairman, was assigned the rather extensive task of coordinating the American Medical Association educational campaign for the state of Wisconsin and the collection of the voluntary A.M.A. assessment. The excellence of the response on the assessment can be judged by the fact that 80 per cent of the doctors paid their $25, and some doctors are still paying into this chance to be part of one of the greatest grass roots campaigns against Old World idealogies that anyone has ever seen.

This year will tell much of the story. Either we, with the help of millions of people alerted by the campaign, will win against the theory that only a central government has the brains and ability to properly manage our lives from the cradle to the grave, or we go down that road with other disillusioned people to complete loss of liberty and democracy.

A committee has been appointed and is preparing to survey the reactions of employers and employees throughout the state on various problems in which they feel the medical profession can be of help.

The prepaid programs are moving ahead. Policies for individuals and single family units are available under both the Wisconsin Plan and Wisconsin Physicians Service. The Coordinating Committee on Prepaid Plans is proving to be a valuable aid in promoting and maintaining the social goals of voluntary sickness insurance plans in this state. If we continually move ahead with increased benefits to the policy holder and fair dues to the doctors, all with an active selling campaign and a sound actuarial premium, we will need to have no fear of cries for compulsory, governmental medicine.

John Wm Truitt MD

Social Morality and the "Cradle-to-the-Grave" Philosophy*

By FRANK G. DICKINSON, Ph. D.
Chicago

OUR HEALTH PROGRESS SINCE 1900†

1. A dozen funerals in 1900—4 for persons who had lived at least 50 years.
   A dozen funerals in 1949—9 for persons who had lived at least 50 years.
2. The older half of the people dying in 1900 had lived 30 years or more.
   The older half of the people dying in 1949 had lived 66 years or more.
3. One thousand babies born in 1900 were destined to live 49,000 years.
   One thousand babies born in 1949 were destined to live 68,000 years.
4. Since 1900 the entire population of the United States has *doubled*. (75 to 150 million)
   Since 1900 the population age 65 and over has *quadrupled*. (3 to 12 million)
5. The LOWEST state maternal mortality rate in 1933 was 4.3.
   The HIGHEST state maternal mortality rate in 1947 was 2.6.

I COME here today* to pay my respects to one of the great universities of the world, one steeped in a fine tradition of scientific inquiry and an open mind. I would also pay a word of tribute to John B. Andrews (Ph. D.) who was a giant in every sense of that term.

The chart above is a copy of a poster that hangs on my office wall. The footnote to it is a memorandum which I use in my customary procedure of distributing materials from our Bureau to the state medical societies. (This item is M-23 in the list of publications of the Bureau of Medical Economic Research of the American Medical Association.)

I should like to talk to you about this poster entitled "Our Health Progress Since 1900." Now the half century is closing. Let's look back at this half century from the standpoint of health. There are many statistics that we could develop. I have tried to make mine simple; perhaps too simple. The changes noted in this chart are in large part, though not entirely, due to health progress. First, in 1900 about one third of the people dying had lived half a century. About three fourths of the people dying this year have lived half a century. Another way to put the same idea (number 2 on the poster) is that the older half of the people dying in 1900 had lived 30 years or more, and the older half of the people dying this year have lived 66 years or more. The median age at death has advanced about 36 years. Probably one of the reasons I was willing to accept my present position is because I have believed for many years that health progress is at once the measure and the core of social progress. Length of life is a comprehensive, rough measure of social progress: a quarter of a century in the heyday of the Roman Empire (for upper class Romans), a third of a century in Germany in 1700; life expectancy at birth was almost a half century in 1900 and almost three score years and ten in 1950 in the United States. Ruskin said it so beautifully, delightfully, in one sentence: "There is no wealth but life." And I would impress upon you with my limited powers the simple fact that, during the first half of the twentieth century, not only have we enjoyed man's greatest half century but we have also endured a social revolution, a social revolution more important than the fall

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† Over a period of several decades a population could age without any change in longevity of life or general health because of: (A) A long decline in the birth rate; (B) A steady increase in the number of *older* immigrants; (C) A considerable decrease in the number of *younger* immigrants. (A) and (C) have, to some extent, speeded up the process of aging since 1900 and accordingly qualify my points 1, 2 and 4 on the chart; but, of course, longevity of life has also increased since 1900, as shown in point 3 on the chart. I strongly suspect that one of the major reasons for the decline in the birth rate has been health progress, which economizes upon the number of babies needed.

* The John B. Andrews Memorial Symposium on Labor Legislation and Social Security, held at the University of Wisconsin on November 4 and 5, 1949, was intended (as stated in the preliminary announcement) "to arouse increased interest in protective labor and social security legislation in colleges and universities and to get the views of people who have given thought to these subjects regarding present needs and future prospects." (The late John B. Andrews was an outstanding leader in social insurance movements and was the Executive Secretary of the American Association for Labor Legislation.) Those in attendance at the symposium were professors and advanced students working in the field of social insurance.

The chairman of the round table on health insurance was Professor Edison L. Bowers, chairman of the department of economics of Ohio State University. Nelson H. Cruikshank, director, Social Security department, American Federation of Labor, and Paul R. Hawley, M. D., chief executive officer, Blue Cross–Blue Shield Commissions, gave prepared talks. Sir James Ross, formerly of the British Ministry of Health, London, England, and I made shorter extemporaneous comments on the matter of health insurance. All of the papers given at the symposium will be published next summer by the University of Wisconsin.—F. G. D.

of the Roman Empire, the Renaissance, the French Revolution, or the Industrial Revolution. This latest social revolution lies in the fact that the distance from the cradle to the grave is much longer for the average man. In 1900 there was no sentiment for "cradle to the grave" schemes. Most of us living in 1900 were close to the cradle. Most of the people living today are far from their cradle days. This social revolution is the basis for the sentiment for "cradle to the grave" schemes, as Sir William Beveridge called them; other people use different names. We are faced primarily with medical and health progress in half a century which have come so fast that we have difficulty digesting them into our social institutions and into our way of life. That, I submit, is the general problem. It breaks down into many specific problems.

Life expectancy, which is the third point of this poster, is a term that I have great difficulty in using because I have been alarmed at the number of people who do not seem to understand that "life expectancy" is a term of limited meaning. The life expectancy computation always refers to the calendar year for which it is computed, and only to that calendar year. Average age at death and life expectancy at birth would be the same in any centuries when health progress was negligible. In 1900, 1,000 babies were expected to live a total of 49,000 years, provided they could live out their whole lives from the cradle to the grave during 1900—obviously a flight of fancy—or while health conditions remained the same as in 1900. But, as a matter of fact, they have lived out their lives under rapidly improving health conditions. About 57 per cent of them were expected to be alive in 1950. Actually there will be about 65 or 69 per cent of them alive in 1950. An average group of 1,000 babies born in 1949 were expected to live a total of 68,000 years. We could go on, and mention the life expectancies at ages 20, 30, 40, 50, and on down the line. Of course, gains in life expectancy have not been so great at higher ages even since 1900. If life expectancy and gains therein were not lower at age 50 than at age 10, we would be entering an age of Methuselahs.

Fourth on this chart is an item of which all of you are very cognizant. While the population of the United States has doubled since 1900, the number of people 65 and over has quadrupled. We might go on and on with these statistics, but I have added just one more—on maternal mortality. In 1933, the first year in which all states required birth and death registration, the highest ranking state had a maternal mortality rate of 4.3 deaths per thousand live births. In 1948, the lowest ranking state had a rate of 2.7. I want to call your attention to the simple fact that the poorest ranking state in this particular index of vital statistics had a rate less than two thirds of that of the best state fifteen years previously. Thus I take issue with anyone who tells the American people that health progress has been limited to the wealthiest portions of the United States. And I might add, for those who delight in making international comparisons of vital statistics, that while Sweden had a maternal mortality rate of 3.1 in 1933 and we had 6.2 the rate in 1948 for Sweden was about 0.9 and for the United States 1.2. And Swedes apparently live longer in Minnesota than they do in Sweden.

We have come a long way in this half century. The problem that we are facing in the discussion today is the result of medical progress aided by better food, better housing, and better sanitation. I should like you to think of it in the larger sense. If I have seemed boastful about our great medical progress since 1900, I have not made myself clear. I feel very humble in the presence of the data on this chart. None of these health accomplishments is good enough for the American people. It is the disturbing premise of the practice of medicine that the doctor cannot win. Let's say that when he saves a woman in childbirth (we have been talking about maternal mortality) he just adds her name to the list of potential victims of cancer years later. Let's say that the patient saved is a laboring man with pneumonia; all the doctor does is to add one more name to the list of potential candidates for heart disease. The doctor cannot win! Those who study these problems must come to understand the limitations on medical practice. They must understand that there are limitations on medical progress itself. The doctor can change only the age and cause of death. Medical care can never be adequate. There is no adequate medical care for the family of a dying man. But the quest for better health, for longer life, for improved medical care will never end; it will go on and on. All that medical care can become is better. We are not talking about a black and white question. We are talking about a problem in which there are only shades of gray. We can only improve; we cannot perfect.

Let us look at the economic side of the question. The American people have chosen to set aside about 96 per cent of their family budgets for items other than medical care. It is not my decision; it is not your decision; it is not the decision of the American medical profession; and it certainly is not the decision of anyone in Washington. It is the decision of all the people. We live in a free society where the consumers are the dictators. It's not so much a question of what they can afford to spend as what they choose to spend for medical care. There may be those among you who think the American people ought to spend less than 96 per cent of their family budget on items other than medical care. This is a problem of education in consumption values, and will remain a problem of education.

Finally, I want to say something that's overly sharp. I think "cradle to the grave" is a scheme whereby those close to the grave would fasten themselves on the paychecks of those closer to the cradle, and ride piggy-back to the grave. The first time that statement came back to me from my secre-

tary it read "piggy-bank" to the grave. Perhaps I should have left it that way.

I think we face a grave problem of social morality. It is not so much a matter of economics. We who are over 50 years of age have the power to make life miserable for the President of the United States, the senators, the congressmen, the governors, the legislators. They all know that the proportionate voting strength of the older population is increasing. We have the voting power. The question is how far we want to go in using our power to exploit youth. I wonder what we older people really intend to do with this great voting power, largely due to health progress. Do we want to have our paychecks clipped for a few years and then retire with the assurance that those at the working ages will provide us with free medical care, free housing, free food—anything you want to name—while we spend our income during our retired years as we see fit?

This is a place noted for a brand of liberalism which I admire because, basically, the liberalism of Wisconsin has always been one of believing enough in reforms to insist upon paying for them. That is the kind of liberalism all of us can admire. The fundamental question underlying all of this discussion today, as I see it, is simply this: What kind of a standard of social morality do you want in this country? That is the basic issue. Do you want this exploitation of youth, do you want to fasten yourselves on the paychecks of youth and ride piggy-back or piggy-bank to the grave, or do you want to pay your own way? Many years ago when we became old enough to vote, we faced a world in which we knew that there was ahead of us a lifetime of working, earning, and saving. My children and your children face a far different prospect as they reach voting age. For our children, we have—I think largely thoughtlessly—created a world in which about all they can look forward to is a lifetime of working, earning, and paying taxes. That, I submit, is not a fair proposition. It is not reasonable. And I believe that youth will find a way to get even with those of us who were born before 1900. It may require only a process of higher and higher prices, higher wages, higher salaries; nowadays higher pensions get into that inflationary spiral and some would add compulsory sickness insurance, by whatever name you choose to call it. But the essential question that we are debating today is one of social morality. Do we want to ride piggy-back to the grave on the shoulders of those who are now children? Do we want to press down upon the brow of our own youth this crown of security thorns? Health progress has given us the voting power.

Introducing the Guest Editorialist

Born 41 years ago in Cloquet, Minn., which shortly thereafter burned down in a forest fire.

Boyhood in Duluth, Minn., Eau Claire, Wis., Minneapolis, Minn., mostly in last-named, where he played with music and journalism while his father urged him to be an honest lawyer and his mother an honest anything. Personally, he always wanted to be a doctor, but there's no known antidote for even small injections of printer's ink. Lured by the University of Wisconsin's reputation in journalism, he came to Madison in 1925 and began asking questions: the first whether the large stone building in the middle of Capitol Square was where the freshmen registered.

Except for brief periods in Minneapolis and Iowa, he's been there ever since, leaving the university in 1929 for a reporter's job that led successsively to state editor, city editor, managing editor, and since 1942, editor of The Wisconsin State Journal. Served stints on various civic and community projects, member of American Society of Newspaper Editors, National Conference of Editorial Writers.

Married; two sons, one of whom plays the drums and football and the other of whom mixes vile chemical experiments while father vainly tries to interest both of them in a medical career.

Newspaper, politically independent, always interested and active in public welfare and medical questions.

Submitting his manuscript with some misgivings, mindful of the man who says, "Some of my best friends are doctors," and of the other man who answers, "How do you keep 'em?"

Sword on the Thread of Fear

FROM the long-ago moment my child mind understood the strange man in our house had saved my mother's life, I have wished I were a doctor. And I always shall.

But it is a good thing that I am not. For even in this, the noblest and blessedest of all professions, I could not work in the chains and gags of my own making. I could not deny myself the freedoms I demand for others. I could not escape the responsibilities I expect to be shared by ditch-digger and college president, housewife and statesman.

I could not learn to be afraid.

And doctors are afraid . . . I wonder of what. The American Medical Association? Politicians? An unenlightened public? Themselves?

They will say it is not fear that has dictated their rigid codes of conduct, their iron-bound oaths and ethics, but rather the necessity of standards and integrity for their protection and for that of the humanity they serve.

But in their understandable—even defensible—determination to keep themselves and their motives above suspicion, the doctors have hampered themselves, have denied their fellow-citizens the fullness of their potentials, and, finally, have suffered to tremble over the heads of all Americans the most vicious threat this generation of freedom has known: socialized medicine.

Why are the doctors to be blamed?

Because they were too long silent, too long aloof, too long a profession apart. They were above the welter and bruises of politics and community argument, yes. But they were not the functioning cogs of a complicated democratic machinery they might have been.

The doctors did not speak up.

Others—plotting politicians, adventurers without faith in or allegiance to Americanism—have connived and shouted.

And, in the absence of a clearer, more convincing voice from the other side, the people have listened to these.

* * *

A general indictment requires specific evidence. Very well.

How many medical men do we find in the politics of any community or state, the politics which, stripped of its sneering connotations, means only the active participation in the democratic process to the extent of the individual's talent? How often do we see our doctors, as private citizens or expert advisors voluntarily coming before our city councils, county boards, and legislatures? So few that they are a surprising rarity.

I recall a long, discouraging fight of many years ago in which a newspaper, in company with concerned laymen, tried to clean up a filthy, mismanaged public medical institution.

It was done, finally, without the major help of the very men who should have been in the front lines: the doctors. Better than anyone else, they realized the dangerous condi-

tions and they knew the measures for their removal. Privately, they would admit it. But publicly—not a word! "Keep us out of this!"

The doctors, for all their ministrations elsewhere, in this case failed the public. And a good share of the public realized it.

I recall the years in which Wisconsin's welfare institutions and its mental health program mouldered into the dark ages.

A few doctors helped, but the people most responsible for the first struggling steps back to decency and adequacy have not been doctors . . . and again, the doctors should have been leading the way.

I am watching in my own county now a blind and stupid board of supervisors do an unconscionable thing in locating a home for the chronically ill and aged in conjunction with an insane asylum and pauper's quarters.

The doctors will serve on advisory committees, yes, and testify when they are called upon, to be sure. But they are not fighting this horrible thing with the voluntary vigor and skill at their command.

The petty, the unthinking, the ignorant rule the day. The people who could save it are silent and aloof . . . and negligent.

* * *

A newspaper office is the focal point of the bewildered, the angry, the questioning for peace of mind.

These complain to us bitterly of hospitals which "let injured, sick people wait until we cough up the money."

They're panic-stricken because they can't find a doctor who will answer a night call.

They want to know why this state's board of medical examiners won't let doctors practice here who are good enough for other states.

We can't answer these because the doctors don't tell us the answers—at least, in some cases not convincingly enough for us to pass them on with assurance and conscience.

These people, then, will listen to somebody, somebody perhaps who has a nostrum, a fake, a package of poison to sell them.

They will listen, and, unless someone arises to talk them out of it, they may buy.

* * *

Why could not the doctors, both as free and individual citizens in a democracy, and as a body of organized, informed opinion, raise the convincing rumpus these situations demand? Why couldn't they have spoken, written, and smacked tables, when one word from a group of responsible, respected medical men would have meant more than a million from anyone else?

Ethics? Codes? Fears?

Then, for all their essentials, they are too expensive.

Roy Matson

RECENT WISCONSIN LICENTIATES

At a meeting held in Madison on January 10–12, the Wisconsin State Board of Medical Examiners licensed the following physicians in the practice of medicine after they had successfully passed an examination:

Name	*School of Graduation*	*Year*	*Address*
Anderson, C. E., Jr.	Illinois	1948	7844 West Harwood, Milwaukee 13
Baker, W. V.	Louisville	1947	3174 North Twenty-Ninth Street, Milwaukee
Balistreri, F.	New York	1948	1525 East Beverly, Milwaukee 11
Baxter, R. H.	Loyola	1948	Milwaukee County Hospital, Milwaukee
Betlach, E. H.	Wisconsin	1946	1432 Morrison, Madison
Bryant, F. W.	Michigan	1948	5000 West Chambers, Milwaukee
Cassidy, J. E.	Loyola	1948	Milwaukee County Hospital, Milwaukee
Coheen, J. J.	Albany	1944	Wisconsin General Hospital, Madison 6
Cooper, J. H.	Wisconsin	1945	1316 Fitchburg Road, Madison
Davis, D. P.	Marquette	1948	2544 North Farwell, Milwaukee
Foley, R. J.	Loyola	1948	8700 West Wisconsin Avenue, Milwaukee
Heath, P., Jr.	Michigan	1948	Wisconsin General Hospital, Madison
Hitchman, R. (n)	Marquette	1948	26 Davis Street, Portsmouth, Va.
Horwich, H.	Toronto	1948	3321 North Maryland, Milwaukee
Jameson, Jane (F)	Wisconsin	1948	4471 North Prospect, Milwaukee
Johnston, H. C.	McGill	1937	318 Court, Madison
Levitas, J. R.	Northwestern	1949	Cook County Hospital, Chicago
Lohrman, G. H.	Marquette	1948	115 North Eighty-Seventh Street, Milwaukee
Martin, Doreen A. (F)	Minnesota	1949	Wabasha, Minn.
Mullaney, G. L., Jr.	Creighton	1948	3930 North Stowell, Milwaukee 11
Murray, J. F.	Virginia	1944	2133 North Forty-Sixth Street, Milwaukee
Muscato, G. V., Jr.	St. Louis	1948	5103 North One Hundred Twenty-Sixth Street, Milwaukee
Parrott, N. A.	Louisville	1948	4052 South Third Street, Milwaukee 7
Robb, Jocelyn I. (F)	Manitoba	1946	1300 University Avenue, Madison
Schmidt, C. H.	Pennsylvania	1948	8700 West Wisconsin Avenue, Milwaukee 13
Stuhler, J. D.	Iowa	1948	727 North Twenty-First Street, Milwaukee
Taira, Y.	Michigan	1944	1821 West Wisconsin, Milwaukee
Toronto, A. F.	Marquette	1948	8844 Watertown Plank Road, Milwaukee 13
Van Vleet, Mary E. (F)	Northwestern	1949	3042 North Prospect, Milwaukee
Waits, C. L.	Wisconsin	1948	2403 Ferry Street, Lafayette, Ind.
Whitmore, Janet M. (F)	Wisconsin	1948	525 Miller Avenue, Madison
Zmolek, E. J.	Iowa	1948	842 South Fifty-Sixth Street, West Allis
Zoeller, A. F.	Louisville	1948	1821 West Wisconsin Avenue, Milwaukee

The following physicians, whose names were not previously published, were granted licenses to practice medicine in the state of Wisconsin in 1949.

Bartzen, P. J.	Marquette	1948	2014 Jarvis Street. Milwaukee 11
Novak, Josephine J. (F)	Wisconsin	1948	Route 2, Box 7, Hartford
Richards, J. N.	Wisconsin	1948	1753 West Congress, Chicago
Stephens, W. E.	Wisconsin	1947	335 Woodland, Oconomowoc

The following physicians were granted licenses by reciprocity by the Wisconsin State Board of Medical Examiners on January 10–12:

Andrews, R. M.	College of Medical Evangelists	1942	Adams
Abronies, W. G.	Northwestern	1943	905 University Avenue, Madison
Axtmayer, R. W.	Marquette	1946	St. Mary's Hospital, Milwaukee
Bayley, H. G., Jr.	Northwestern	1942	Veterans Administration Center, Wood
Bourget, G. E.	Minnesota	1945	Hudson
Cheplin, Muriel J. (F)	Syracuse	1947	Mount Sinai Hospital, Milwaukee
Crepea, S. B.	Tulane	1942	University Club, Madison
Ellinger, A. J.	Minnesota	1943	1411 Wauwatosa Avenue, Wauwatosa
Epperson, K. D.	Northwestern	1947	Route 4, Box 45, Oconomowoc
Frethem, A. A.	Minnesota	1946	3710 Tenth Avenue, Kenosha
Hartson, R. C.	McGill	1943	16 South Henry, Madison
Hiken, L. L.	Marquette	1947	2750 West Fifteenth Place, Chicago
Hipps, C. J.	Colorado	1944	Denmark
Jones, F. S.	Boston	1946	1337 Mound Street, Madison
Locher, W. G.	Syracuse	1947	315 Sycamore Road, West Reading, Pa.
Logan, R. S.	Indiana	1943	Route 1, Urbana, Ind.
McIllece, Patricia E. (F)	Nebraska	1947	Wisconsin General Hospital, Madison

Name	*School of Graduation*	*Year*	*Address*
MacMillan, D. G.	Minnesota	1940	122½ North Main Street, Rice Lake
Meyer, J. F.	Wisconsin	1947	Milwaukee Children's Hospital, Milwaukee
Mueller, L. E.	George Washington	1917	2213 North Sixty-First Street, Wauwatosa
Murphy, T. E.	Long Island College	1943	10458 One Hundred Twenty-Eighth Street, Richmond Hill, N. Y.
Olsman, L.	Illinois	1938	6500 Irving Park Boulevard, Chicago
Olson, D. M.	Minnesota	1946	Milwaukee County Hospital, Milwaukee
O'Neill, C. J.	Illinois	1943	3831 East Avenue, Berwyn, Ill.
Parmley, L. F., Jr.	Virginia	1943	122 West Lakeside Street, Madison
Quinn, R. W.	McGill	1938	Wisconsin General Hospital, Madison
Sanders, D. D.	Oregon	1946	Milwaukee County Hospital, Milwaukee
Sattler, C. A.	Rush	1940	1430 Tulane Avenue, New Orleans
Scheid, J. M.	Loyola	1943	6418 Lakewood Avenue, Chicago
Siebecker, K. L.	Wisconsin	1940	Wisconsin General Hospital, Madison
Slater, R. L.	Jefferson	1921	466 Racine Street, Menasha
Smejkal, W. F.	Illinois	1942	7633 West Palatine Avenue, Chicago
Sonneland, A. M.	Creighton	1946	St. Mary's Hospital, Madison
Thorpe, R. F.	Illinois	1944	1121 Fairmont, Manitowoc
Weber, G. R.	Indiana	1943	Kenosha Bank Building, Kenosha
Wood, H. W., Jr.	Medical College of Virginia	1942	327 Merritt Street, Oshkosh
Zagaria, J. F.	Minnesota	1941	St. Mary's Hospital, Wausau

The following physicians, not previously reported, were granted licenses by reciprocity following examinations in 1949:

Fuerste, F. Jr.	Iowa	1945	Milwaukee County Hospital, Milwaukee
Hastings, E. V.	Marquette	1944	Milwaukee County Hospital, Milwaukee
Herzon, H.	Illinois	1944	2442 West Farwell, Chicago
Johnson, M. H.	Loyola	1944	904 West Adams Street, Chicago
Thomas, W. D.	Columbia	1944	Mayo Clinic, Rochester, Minn.

Society Proceedings

Brown—Kewaunee—Door

Guest speaker at the March 9 meeting of the Brown–Kewaunee–Door County Medical Society was *Dr. Clifford Kalb*, of Milwaukee, who talked on "Allergic Problems in General Practice." *Dr. Fred O. Kuehl* of Green Bay discussed the presentation. The meeting was held following a dinner at the Northland Hotel in Green Bay.

Chippewa

Two staff members from the Mayo Clinic, Rochester, Minn., were guests of the Chippewa County Medical Society on March 14, when they met at the Hotel Northern in Chippewa Falls. Dr. W. M. McConahey discussed "The Management of Diabetes," and Dr. J. H. Pratt spoke on "Emergency Gynecologic Procedures."

Crawford

The Woman's Auxiliary served a dinner to members of the Crawford County Medical Society on March 16. The meeting was held at the home of *Dr. T. F. Farrell* in Prairie du Chien.

Dodge

Two speakers sponsored by the State Board of Health and the Wisconsin Heart Association were present at the February 23 meeting of the Dodge County Medical Society, held at the Lutheran Deaconness Hospital in Beaver Dam. *Dr. Chester M. Kurtz*, Madison, spoke on hypertension, and *Dr. Henry M. Suckle*, also of Madison, discussed sympathectomy for hypertension.

At a meeting of the Society at the Central State Hospital in Waupun on January 26, *Dr. J. F. Klepfer* and R. E. Warmington spoke on treatments used at the hospital. The Red Cross blood bank was discussed, and the present fee schedule was made known to the new members of the society. A reception and dinner, sponsored by Mrs. Klepfer, followed the meeting.

Eau Claire—Dunn—Pepin

Illustrating his talk with motion pictures, *Dr. A. L. Van Duser*, Madison, presented the subject of "Carcinoma of the Breast; Methods of Diagnosis," to the Eau Claire–Dunn–Pepin County Medical Society at the Hotel Eau Claire in Eau Claire on March 27. Doctor Van Duser is chief of the cancer section of the Wisconsin State Board of Health.

Fond du Lac

Meeting at Schreiner's Restaurant in Fond du Lac on February 23, members of the Fond du Lac County Medical Society heard a talk by *Dr. S. F. Morgan*

of Milwaukee. The doctor talked on "Rheumatic Fever; its Diagnosis and Treatment." The topic was discussed by *Dr. A. M. Hutter*, Fond du Lac, president of the Wisconsin Heart Association. At the business session, two resolutions were passed, the first of which was as follows:

Realizing the distinct benefits obtainable to society and to the medical profession, the Fond du Lac County Medical Society hereby expresses its approval of participation of the Fond du Lac County Chapter of the American Red Cross in the national blood program.

It further pledges its whole cooperation in any phase requiring such cooperation, including that of public education and recruitment.

In this connection the president appointed a medical advisory committee to the American Red Cross Blood Program, consisting of *Drs. R. W. Steube*, Fond du Lac, chairman; *W. H. Schuler*, Ripon; *W. J. Petters*, Waupun; and *J. S. Wier*, Fond du Lac.

Copies of the following resolution were sent to Senators Wiley and McCarthy and to Congressman F. B. Keefe:

In the interests of medical science, of the physical welfare of the nation, and of the magnificient system of American medicine, the Fond du Lac County Medical Society places on public record, and urges you to maintain, a firm stand against any form of compulsory health insurance, and any of its more subtle entering wedges.

Forest

Election of officers was held at a meeting of the Forest County Medical Society held at Laona on December 16. *Dr. O. S. Tenley* of Wabeno was named president for 1950; and serving with him will be *Drs. G. W. Ison* of Crandon, vice-president; *B. S. Rathert*, Crandon, secretary; *G. E. Carroll*, Laona, delegate; and *O. S. Tenley*, Wabeno, alternate delegate.

Green Lake—Waushara

R. H. QUADE

"Emergency Treatment of Head Injuries" was the title of a paper presented to the Green Lake–Waushara County Medical Society when it met at the Hotel Whiting, Berlin, on March 16. *Dr. R. H. Quade*, neurosurgeon of Neenah, was the guest speaker. At the business session a fee schedule for county welfare cases was adopted, to be presented to the respective county boards. A grievance committee was appointed to settle disputed claims for county welfare cases, and a commitee, consisting of *Drs. Grant C. Stone*, Berlin, chairman; *Roy Hong*, Wild Rose; and *A. C. Theiler*, Princeton, was appointed to study the need and method of conducting a diabetes detection survey in these counties.

Jefferson

Dr. A. R. Curreri of Madison was the guest speaker for the Jefferson County Medical Society when they met at Roehl's Tearoom in Lake Mills on March 16. Doctor Curreri, who is associate professor of surgery at the University of Wisconsin Medical School, discussed "Breast Disease."

Kenosha

A member of the faculty at Marquette University School of Medicine was the guest speaker at the March 7 meeting of the Kenosha County Medical Society, held at the Elks Club in Kenosha. *Dr. Gerhard D. Straus*, an assistant clinical professor of otolaryngology at Marquette, discussed "Modern Ear Problems," illustrating his talk with slides.

Polk

Dr. W. A. Fischer of Frederic was host to the Polk County Medical Society on February 16 at Friberg's Restaurant in Frederic, when the group had Dr. George M. Tangen of Minneapolis as its guest speaker. Doctor Tangen, associate professor of otolaryngology at the University of Minnesota Medical School, discussed "Nasal Obstruction."

On January 19 the group met at the St. Croix Inn at St. Croix Falls, as guests of *Dr. Fred B. Riegel* of that city. Dr. Robert Howard, instructor in internal medicine at the University of Minnesota Medical School, presented the subject of "Differential Diagnosis of Jaundice," demonstrating by means of a movie film, the use of an instrument for liver biopsy.

Price—Taylor

Following a dinner at the Northwoods Inn, members of the Price–Taylor County Medical Society met at the Leahy Clinic in Park Falls on February 25 to hear a talk by *Dr. Herman H. Shapiro* of Madison. Doctor Shapiro, an associate professor of medicine at the University of Wisconsin Medical School, pointed out "Recent Advances in Treatment of Congestive Heart Failure."

Richland

A talk on immunization was given by *Dr. Pierce D. Nelson*, Madison, at the March 7 meeting of the Richland County Medical Society, held at the Richland Hospital in Richland Center. Doctor Nelson is the health officer of district 1 of the Wisconsin State Board of Health.

"Methods of Diagnosis and Treatment in Diabetes" were presented to the group at a meeting on February 14 by *Dr. Edward L. Perry* of La Crosse. This meeting was also held at Richland Hospital. *Dr. Dayton Hinke* is now serving as president of the group, succeeding *Dr. Robert Borgerson*, who recently moved from Richland Center.

Shawano

Coronary heart disease was the subject discussed at a meeting of the Shawano County Medical Society at the Shawano Hospital on February 21. *Dr. Lamont R. Schweiger*, an assistant clinical professor of medicine at Marquette University School of Medicine, was the guest speaker, sponsored by the State Board of Health and the Wisconsin Heart Association.

Waukesha

Meeting at the Veterans Administration Hospital in Waukesha on March 1, members of the Waukesha County Medical Society heard talks by two staff members of the hospital. *Drs. M. C. Thomas*, superintendent, and *H. S. Houston* discussed tuberculosis. Members of the group were joined by the Woman's Auxiliary for dinner in the staff dining room of the hospital.

Washington—Ozaukee

Dr. William R. Kreul of Racine was present at a meeting of the Washington–Ozaukee County Medical Society on February 25 to discuss anesthesia. The group met at the Jackson Hotel in Jackson. The meeting followed a dinner at which members of the Auxiliary were guests.

Waupaca

Dr. K. L. Haman, Manawa, was elected president of the Waupaca County Medical Society at a dinner meeting held February 9 at the Marson Hotel, Clintonville. He succeeds *Dr. C. P. Arnoldussen*, Fremont. Other new officers include *Drs. R. H. Pfeifer*, Clintonville, vice-president; and *J. W. Monsted*, New London, secretary. Following the business session, *Dr. John D. German*, Clintonville, addressed the group on "The Management of Massive Upper Gastrointestinal Tract Hemorrhage."

Winnebago

F. F. ROSENBAUM

"Diagnosis and Treatment of Disorders of Cardiac Rhythm" was the subject presented at a meeting of the Winnebago County Medical Society at Shenar's Restaurant near Oshkosh on March 2. *Dr. Francis Rosenbaum*, an assistant clinical professor of medicine at Marquette University School of Medicine, was the guest speaker.

Wisconsin Surgical Club

Members and guests of the Wisconsin Surgical Club returned from their annual clinical tour on March 12, after journeying east to Washington, D. C., and southward through Atlanta, Ga. In Richmond, Va., they were guests of Drs. I. A. Bigger and Herbert C. Lee, the latter a native of Wisconsin, and of the department of surgery of the Medical College of Virginia. Two days were spent at the University of Virginia, Charlottesville, Va., Dr. Edwin P. Lehman and members of the surgical department being hosts to the group. Leaving there on March 9, they travelled to Atlanta, Ga., where they were the guests of Dr. Daniel C. Elkin, Whitehead professor of surgery at Atlanta University. They left for Chicago on March 11. The programs and surgical clinics were excellent, according to the Wisconsin surgeons, each of the centers emphasizing a different phase of surgical investigation. Guests of the Surgical Club on the trip were *Drs. Warner S. Bump*, Rhinelander; *J. W. McRoberts*, Sheboygan; and *William E. Clark*, Oshkosh.

AMERICAN MEDICAL GOLFING ASSOCIATION ANNOUNCES DATES OF THIRTY-FOURTH TOURNAMENT

The thirty-fourth tournament of the American Medical Golfing Association will be held on the two golf courses of the Olympic Golf Club, San Francisco, on June 26, the opening day of the 1950 convention of the American Medical Association. Fellows of the A. M. A. who plan to participate should send, as soon as possible, their name, handicap, and section in medicine in which they will register to Secretary Bill Burns, 2020 Olds Tower, Lansing 8, Michigan. This will assist the local committee in making the necessary arrangements. The starting committee will assist players from the different states to arrange games with like handicaps, age, and specialty.

The detailed program of the tournament will appear in the Convention Number of the Journal of the American Medical Association.

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News Items and Personals

Dr. J. C. Hassall Retires as Head of Sanitarium

The trustees of Rogers Memorial Sanitarium of Oconomowoc recently announced the retirement of *Dr. James C. Hassall* as medical director of the institution, effective March 20. Doctor Hassall has been connected with the sanitarium since April 1926 and has been its medical director since the death of *Dr. Arthur W. Rogers* in 1937. He will continue his work there now in the capacity of psychiatric consultant.

Doctor Hassall is succeeded by *Dr. Owen C. Clark*, who served as an assistant physician at the sanitarium for several years under Doctor Rogers and later under Doctor Hassall. Following three years in war service, Doctor Clark became a member of the staff of Sacred Heart Sanitarium in Milwaukee, where he has been for the past five years.

Rotary Club Honors Dr. A. T. Nadeau of Marinette

A half century of medical service to Marinette was recognized by the Rotary Club of that city on March 27, when they sponsored a dinner honoring *Dr. A. T. Nadeau*, physician at Marinette since 1902. The event was held at the Riverside Country Club, Menominee, Mich. Guests included *Drs. John W. Truitt*, Milwaukee, president of the State Medical Society; *S. E. Gavin*, Fond du Lac, chairman emeritus of the Council; and *E. M. Dessloch*, Prairie du Chien, councilor; and C. H. Crownhart, secretary, and Roy T. Ragatz, assistant secretary of the Society. Present also were a son, Dr. A. T. Nadeau, Jr., of Grenada, Miss., and a brother, *Dr. Emil Nadeau*, Green Bay. An award, "Red Roses to the Living," which set forth the achievements of the doctor both in community service and in state medical circles, was presented to Doctor Nadeau. The award is the highest honor bestowed by the Rotary Club and has been presented on only two previous occasions.

The doctor, a native of Quebec, Canada, is a graduate of Rush Medical College. He is a charter member of the Marinette County Medical Society and a life member of the State Medical Society. From 1945 to 1947 he served as a member of the Council of the State Medical Society, and on several occasions has been president of his county medical society.

Dr. E. M. Poser Feted by Columbus Citizenry

Two hundred and fifty persons attended the citizens' testimonial dinner at Columbus on March 14, to honor *Dr. E. M. Poser*, who has been active in the

Dr. H. F. Schroeder (left) presents plaque to Dr. A. T. Nadeau during banquet honoring fifty years of service by Doctor Nadeau. Seated are a brother, Dr. Emil Nadeau of Green Bay, and a son, Dr. A. T. Nadeau, Jr., of Grenada, Miss.

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medical profession in that community for forty-five years. The event, sponsored by the Chamber of Commerce, was held in the Zion Lutheran Church parlors in Columbus. A plaque was presented to the doctor, and men who had been associated with him during his long practice reminisced about his accomplishments.

Doctor Poser, a native of Kewaunee, received his M.D. degree from Rush Medical College, Chicago, in 1893. Prior to that time he had received a degree in pharmacy from the University of Wisconsin and worked as a druggist in Stoughton for two years. Following a brief medical practice in Milwaukee, he came to Columbus in 1894. The doctor has four sons, three of whom are physicians. They are Drs. *Robert* and *Rolf*, Columbus, and Edward, Chicago. The fourth is an attorney at Neenah.

Pewaukee Holds "Doctor Egloff Night"

A Pewaukee physician for thirty-five years, *Dr. Leo W. Egloff* was honored at a Chamber of Commerce dinner on February 9 at the American Legion hall in Pewaukee. "Doctor Egloff Night" was the community's expression of thanks for the doctor's continuous medical practice in that community since 1914.

The doctor is a native of Fort Atkinson. He attended Marquette University School of Medicine, receiving his medical degree in 1910. That year he established a practice at Elkhart Lake, moving to Pewaukee four years later. He has served as health officer of Pewaukee and is a member of the staff of the Waukesha Memorial Hospital.

Fremont Physician Named "Most Valuable Citizen"

The "Most Valuable Citizen" in Fremont for 1949 was *Dr. C. P. Arnoldussen*, physician in that community since 1937. The selection was made by a committee from the Weyauwega Lions Club, and presentation of the award took place at a meeting of the club at Archie's Hotel, Weyauwega, on February 13. Doctor Arnoldussen located in Fremont in September 1937, shortly after his graduation from the Marquette University School of Medicine. He recently served as president of the Waupaca County Medical Society.

Dr. G. E. Miller Moves to Tennessee

Dr. G. E. Miller, a Marshfield physician since 1946, left on January 14 for Johnson City, Tenn., where he is now associated with the McKee–Wilson Hospital. A native of Marshfield, Doctor Miller served in the medical department of the Army Air Corps following his graduation from Northwestern University Medical School. After his military discharge in 1946, he joined the staff of the Marshfield Clinic. Later he took postgraduate studies in eye, ear, nose, and throat work at the University of Wisconsin Medical School, returning to Marshfield in July 1947 to be associated with the clinic and St. Joseph's Hospital.

Oconto Physicians Become Associates

Two Oconto physicians—*Drs. Herman A. Aageson* and *Forrest E. Zantow*—became associated on January 16, combining their offices in those formerly occupied by Doctor Aageson. Doctor Aageson has been practicing in Oconto since March 1941; Doctor Zantow, since July 1948.

Dr. L. J. Earney Joins Lake Geneva Physician in Practice

Dr. Lyman J. Earney, formerly of Eugene, Ore., recently became associated with *Dr. D. H. Jeffers* at Lake Geneva. Doctor Earney, a graduate of Marquette University School of Medicine, served a residency in general surgery at the Milwaukee County General Hospital and was an assistant instructor in anatomy in the graduate school at Marquette for a time. During World War II he served for four years as a post surgeon and anesthesiologist.

Dr. J. P. Skibba Certified by Specialist Board

Dr. Joseph P. Skibba, Appleton physician, was recently certified by the American Board of Urology, following an examination by the Board. Doctor Skibba practiced at Kaukauna before entering military service during World War II. During the war he was head of the department of urology at the United States Naval Hospital Santa Marquerita Ranch, Oceanside, Calif. In 1946 he entered practice in Appleton, where he is on the staff of St. Elizabeth Hospital.

Menasha Doctor Named Delegate of General Practice Group

Dr. W. B. Hildebrand was elected to the congress of delegates of the American Academy of General Practice at the national convention of the organization held in February at St. Louis. He will serve for a three year term. Doctor Hildebrand, a charter member of the Wisconsin chapter, has served as secretary-treasurer since its organization.

During the convention, the Wisconsin chapter, met for a luncheon at the Hotel Jefferson, where *Dr. George E. Forkin*, Menasha, president of the state group, presided.

Assistant Health Director Named at West Allis

Dr. Margaret Pirsch of Kenosha took over the duties of assistant health commissioner for that city on March 16. The doctor, who has been in private practice in Kenosha, succeeds Dr. Ruth Stern.

Medical Staff Meets at Neenah

"A Survey of Gout" was the topic presented by *Dr. R. A. Jensen*, Menasha, at a meeting of the medical staff of the Theda Clark Memorial Hospital, Neenah, on February 24. Doctor Jensen has practiced in Menasha since 1938, with the exception of a period in military service during World War II.

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—EDITOR'S NOTE

SOCIETY PROCEEDING

Rock

Dr. G. L. Thomas, Janesville, discussed "Low Back Disability" at a meeting of the Rock County Medical Society at the Cozy Inn in Janesville on February 28. The group passed the following resolution in memory of the late *Dr. Frank C. Binnewies:*

Dr. Frank Binnewies having departed this life at the close of 1949, be it resolved that the Rock County Medical Society record upon its proceedings its sincere regret and sense of loss at the passing of our long time member and respected colleague and friend who, after many years of service to his community, had attained the venerable age of 83.

Be it further resolved that the society extend to Dr. Binnewies' surviving family our sympathy and heartfelt condolences, being assured that the Doctor's relatives and many friends find comfort in the attainments of his long and useful life.

THIRD DISTRICT NEWS

Dr. H. K. Tenney Addresses Foster Parents

Speaking before 200 foster parents in Madison on March 29, *Dr. H. Kent Tenney*, Madison pediatrician, discussed the care of children who have been taken into homes on a temporary basis. The event was a gathering of foster mothers and fathers in the Dane County area and was sponsored by the Foster Home Committee Welfare Council and the Social Service Department of the Women's Club. Doctor Tenney is associate professor of pediatrics at the University of Wisconsin Medical School.

Dr. G. L. Thomas Opens Practice in Janesville

Dr. George L. Thomas, who has been associated with the Pember–Nuzum Clinic, Janesville, opened a private practice in that city on March 27. He had been associated with the clinic from 1937 to 1943, at that time beginning postgraduate work in orthopedic surgery at the Lahey Clinic in Boston. He returned to Janesville in 1946.

Board of Health Directors Join American Board

Dr. Carl N. Neupert, state health officer, and *Dr. E. H. Jorris*, assistant state health officer, recently received their certificates as members of the American Board of Preventive Medicine in Public Health. *Drs. Milton Feig*, of Green Bay, and *Allan Filek, Charles K. Kincaid*, and *Arthur R. Zintek*, all of Madison, took the examination at Chicago in February and have been notified that they will soon receive their certificates.

Australian Physician Lectures at University of Wisconsin

An Australian physician, Dr. Edward Derrick, was the principal speaker at a University of Wisconsin Medical School convocation on March 17. The doctor is a specialist in virus and rickettsial disorders and is recognized for his work in diagnosis and treatment of Q fever.

SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

An abstract of the paper winning first prize in the Horace Manchester Brown Memorial Essay contest was presented by *Dr. Anthony V. Pisciotta*, Wauwatosa, at the March 21 meeting of the Milwaukee Academy of Medicine, held at the University Club of Milwaukee. The title of the paper was "Clinical and Pathologic Effects of Space-Occupying Lesions of the Bone Marrow." Guest speaker at the meeting was Dr. Edgar V. Allen, consultant in medicine at the Mayo Clinic, Rochester, Minn., who discussed "Intravascular Thrombosis."

Milwaukee Neuro-Psychiatric Society

A farewell party for *Dr. Gilbert J. Rich* was held by members of the Milwaukee Neuro-Psychiatric Society at the University Club of Milwaukee on March 15. An interesting program on mental hygiene, prepared by *Drs. Saul K. Pollack, W. H. Studley*, and *Harold T. Schroeder*, was presented.

Milwaukee Oto-Ophthalmic Society

A dinner meeting was held by the Milwaukee Oto-Ophthalmic Society at the U. S. Veterans Hospital, Milwaukee on March 28. *Drs. John B. Hitz*, senior consultant and *Erwin E. Grossmann*, attending con-

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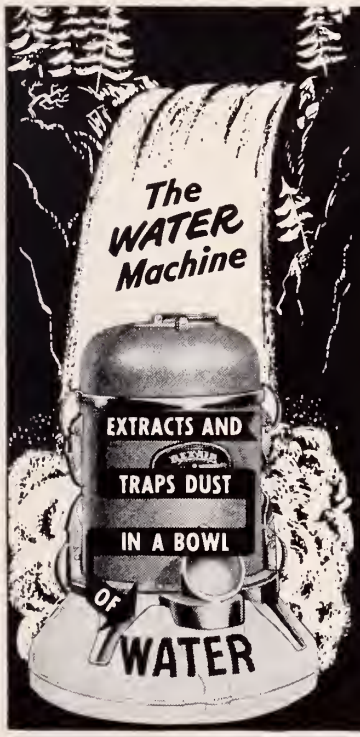

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sultant, presented cases of interest to the members, and *Drs. Arvid Holm* and *Thomas Burns* presented scientific papers. Doctor Holm discussed "Stellate Ganglion Block in the Relief of Angiospasm," and Doctor Burns pointed out the "Uses of Intravenous Novocaine in Ophthalmology." The latter paper was discussed by Dr. B. Anthony Tella, chief of the department of anesthesiology at the hospital.

Dr. Clifford H. Kalb, a fellow of the University of Illinois Graduate School, was the guest speaker at the February 28 meeting of the society, held at the Milwaukee Athletic Club. Doctor Kalb spoke on "Allergic Phases of Eye, Ear, Nose and Throat Work."

TWELFTH DISTRICT NEWS

Dr. T. L. Squier Named President of National Allergists' Group

T. L. SQUIER

Dr. Theodore L. Squier, Milwaukee physician for twenty-five years, was elected president of the American Academy of Allergy at the annual convention of the organization in Los Angeles on March 7. Last year he was vice-president of the academy, and from 1946 to 1948 he served as secretary.

The doctor, a professor of internal medicine at Marquette University School of Medicine, specializes in allergy. He is on the staffs of Columbia and Milwaukee County hospitals and is a consultant in allergy at the Milwaukee Children's hospital. He is a past president of the Milwaukee Academy of Medicine and served as secretary of that organization for seven years.

Dr. E. C. Schmidt Certified by Specialist Board

Dr. Edward C. Schmidt, Milwaukee physician, was recently certified as a diplomate by the American Board of Psychiatry and Neurology. The doctor, a graduate of the University of Wisconsin Medical School, completed a two year residency in psychiatry at the Milwaukee Sanitarium, Wauwatosa, and served a fellowship in neurology at the Mayo Clinic, Rochester, Minn.

Marquette University Holds Medical Clinics

The annual spring clinics of the Marquette University School of Medicine were held on March 17 and 18 at the auditorium of the medical school and at the Veterans and Milwaukee County hospitals. A banquet was held in the Crystal Ballroom of the Hotel Schroeder on Saturday evening, at which time the alumni award was presented to Dr. Thomas J. Canty for his work in rehabilitation of naval amputees. Dr. Edward Compere, associate professor of surgery at Northwestern University Medical School, addressed the group at the Milwaukee Athletic Club on Friday evening, at a meeting of the Medical Society of Milwaukee County. His subject was "The Recognition and Treatment of the More Common Injuries of the Wrist."

The first session of the clinics was held at the Veterans Hospital, with *Dr. Forrester Raine* serving as moderator. *Dr. F. H. Haessler* spoke on "The Use of Tuberculin", *Dr. Maurice Hardgrove* discussed "Hypercorticoidism"; *Dr. Howard Lee* talked on "Management of Bronchial Asthma"; *Dr. Robert Irwin* discussed "Present Day Treatment of Urinary Infections"; and *Dr. Frank Millen* spoke on "The Usefulness of Encephalograms."

At the medical school auditorium on Friday afternoon *Dr. Dexter Witte* was moderator. Speakers were *Drs. Roland Cron,* discussing "Infertility"; *Robert Haukohl,* naming the "New Concepts of Pancreatic Disease"; *Harold Bruskewitz,* speaking on "Urinary Tract Complications following Surgery"; *Richard Foregger* talking on "The Effect of Curare on Respiration"; and *Millard Tufts* and Richard Klein telling about "Experiences with Intravenous Procaine in Treating Arthritis."

On the morning of the second day, *Dr. Joseph M. King* was the moderator at the Milwaukee County Hospital. "X-Ray Diagnosis of Small Bowel Lesions" was discussed by *Dr. Jerome Marks;* "Unusual Carcinoma of the Thyroid Gland" was the subject presented by *Dr. H. A. Devine;* "Fractures about the Ankle" were discussed by *Dr. Joseph Regan;* "Treatment of Hypertension by the General Practitioner" was the subject discussed by *Dr. Norman Erdmann;* and "Common Skin Disorders" was the title of a presentation by *Dr. H. J. Farrell.*

Following a luncheon at the gymnasium of Marquette University, *Dr. Robert Purtell* was the moderator at the closing session, held at the auditorium of Marquette University School of Medicine. *Dr. Joseph Shaiken* discussed "The Problem of Gastric Ulcer"; *Dr. Thomas J. Marland* spoke on "Sodium, Potassium, and Chlorine Metabolism and Water Balance"; *Dr. C. S. Rife* presented a paper on "Intestinal Obstruction"; and *Dr. Samuel Kohn* talked on "Masked Hypothyroidism in Children." The Reverend Anthony Berens, S. J., then presented the alumni award to Doctor Canty, who addressed the group on "Amputation Rehabilitation."

University of Wisconsin Professor Lectures at V. A. Hospital

Dr. Van R. Potter, professor of oncology at the University of Wisconsin Medical School, lectured at the United States Veterans Administration Hospital, Wood, on March 16. His subject was "Cellular Respiration and Narcotics."

A Doctor WHO RAISED HER OWN BABY ON BAKER'S SAYS...

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T. J. Petrick, Columbia Hospital, Milwaukee.
R. S. Merrill, 2522 North Lake Drive, Milwaukee.
W. C. Webb, 2925 South 34th Street, Milwaukee.
H. C. Sprecher, 2228 North 115th Street, Wauwatosa.
L. J. Kreissl, Jr., 231 West Wisconsin Avenue, Milwaukee.
Irvin Becker, Veterans Administration, Wood.
J. E. Sinsky, St. Joseph's Hospital, Milwaukee.
A. W. Limberg, Box 92, Glenwood City.
R. R. Liebenow, 401½ Main Street, Stevens Point.
Elizabeth Baldwin, Marshfield.
C. J. Ryan, Arpin.
J. P. Springer, Elmwood.
F. L. Whitlark, Amery.
J. A. Salick, 2525 Winnebago Street, Madison.
T. H. Lorenz, 1300 University Avenue, Madison.
J. F. Wepfer, 1308 Drake Street, Madison.
Elizabeth A. Steffen, Racine.
F. J. Brown, 111½ North Bridge Street, Chippewa Falls.
B. F. Rahn, Cadott.
C. F. Peabody, 1300 University Avenue, Madison.
C. J. Becker, 2303 North 8th Street, Milwaukee.
W. J. Swift, 723—58th Street, Kenosha.
R. G. Handeyside, Palmyra.
D. M. Cowgill, City Health Department, Eau Claire.
P. P. Meighan, Whitewater.
R. F. Swanson, Whitehall.
D. E. Olson, Statesan.
H. F. Schloemer, 211 West Main Street, Waukesha.
W. G. Smirl, Eagle.
J. W. Kimmel, Eagle.
P. L. Eisele, O'Reilly Veterans Hospital, Springfield, Missouri.
E. E. Kern, Mukwonago.
F. W. Reichardt, 1300 University Avenue, Madison.
M. G. Marra, Amery.
J. K. Fulton, 214 North Superior Street, Appleton.
S. B. Crepea, University Club, Madison.
R. C. Hartsan, 16 South Henry Street, Madison.
J. R. Steeper, 16 South Henry Street, Madison.
G. J. Egan, 319 Main Street, La Crosse.
A. A. Cook, 1707 Main Street, La Crosse.
R. A. Richards, 1220 Dewey Avenue, Wauwatosa.
J. R. Couch, 7006 West Greenfield Avenue, Milwaukee.
O. H. Stokke, 2200 West Kilbourn Avenue, Milwaukee.
R. B. Leitschuh, Veterans Administration, Wood.
A. A. Bullock, Jr., 2200 West Kilbourn Avenue, Milwaukee.
Richard Minton, Veterans Administration, Wood.
F. B. Landis, Veterans Administration, Wood.
V. V. Quandt, Hartford.

Change of Address

C. W. Taylor, Oconomowoc, to State Hospital, Raleigh, North Carolina.

H. F. Avery, Milwaukee, to 37 Smith Road, Hingham, Massachusetts.

R. H. Evers, Madison, to Rocky Knoll Sanatorium, Plymouth.

H. J. Olson, Milwaukee, to 415 Avondale Avenue, Brentwood Park, Los Angeles, California.

G. J. Schroth, Milwaukee to 505½ Third Street, Wausau.

E. F. Winter, Strum, to Hay Building, Oshkosh.

F. D. Swan, Brodhead, to Augustana Hospital, 411 West Dickens, Chicago, Illinois.

O. C. Clark, Milwaukee, to Rogers Memorial Sanatorium, Oconomowoc.

E. L. MacVicar, Milwaukee, to 420 Seventh Street, Racine.

MARRIAGES

Dr. Volney B. Hyslop and Carolyn Seely, Milwaukee, on March 8.

Dr. Marjorie Piehl, Madison, and Dr. Norman H. Harris, San Francisco, on March 3.

Dr. Carol Tomlinson to Frank W. Matthay, Janesville, on February 14.

DEATHS

Dr. Wenzel M. Wochos, Kewaunee physician for forty-seven years, died at a hospital in Green Bay on March 15. The doctor was 76 years old.

The doctor was born in Kewaunee County on August 16, 1873. He received his medical degree from the University of Illinois College of Medicine in 1903, and shorty afterward entered practice in Kewaunee. In 1913 he took postgraduate work in Vienna, Austria. He was one of the founders of Red Cross work in Kewaunee County and had continued to be active in the organization. Until 1948 he had served as Kewaunee County physician, and during World War I he was a member of the county Selective Service board. He had also served on the Kewaunee County High School board for thirty-three years.

Doctor Wochos held membership in the American Association of Industrial Physicians, Brown–Kewaunee–Door County Medical Society, State Medical Society, and American Medical Association.

Two sons survive.

Dr. Kenneth A. Swartz, physician at Waupun since 1927, died suddenly while attending a staff meeting at a Beaver Dam hospital on March 9. He was 51 years old.

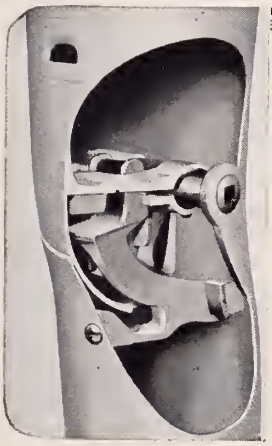
AS IT LOOKS TO YOUR STATE BOARD OF HEALTH

(Continued from page 307)

III. State

A. On September 16, 1949, the Wisconsin State Board of Health approved the use of BCG in the state of Wisconsin under the protocol of the Research Foundation, in groups recommended by the American Trudeau Society. The Board wishes to cooperate by extending its approval to individual projects which come under these safeguards.

The evidence available by which one can judge the efficacy of BCG is based to a large extent upon experiments which can be criticized because of either improper selection of controls, a short duration of observation, or the difficulty of evaluating an immunization procedure where one must of necessity base his conclusions on the prevalence of mortality. However, even though of limited duration, well controlled studies in the United States, such as those of Aronson and Palmer, indicate that a degree of protection is offered; therefore, it looks to your Board of Health as though persons responsible for preventive medicine must reexamine the feasability of offering BCG to certain indicated groups.—A. R. ZINTEK, M.D.



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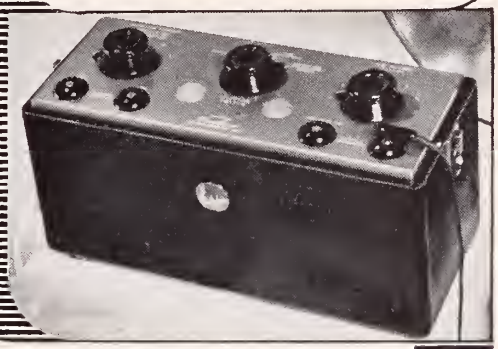

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Born at Middletown, Iowa, on July 16, 1898, the doctor was graduated from Marquette University School of Medicine in 1926. He interned at the Milwaukee County Hospital, entering practice at Waupun in 1927. He operated the Clark–Swartz Clinic with the late Dr. F. T. Clark until the death of the latter five years ago.

The doctor was a member of the American Academy of General Practice, the Fond du Lac County Medical Society, the State Medical Society, and the American Medical Association. Survivors include his wife, his mother, and a daughter.

Dr. Henry S. Smith, retired Cudahy physician, died at his home in Shorewood on February 17 at the age of 78 years. The doctor had served as medical director of Cudahy Brothers for fifteen years.

A native of Galina, Ill., Doctor Smith received his degree in medicine from Rush Medical College in 1896. Following internship at Presbyterian Hospital in Chicago, he practiced in Michigan for twenty-six years before entering practice in Cudahy. From 1925 to 1940 he was medical director of Cudahy Brothers, and for twenty-four years he served as medical examiner for the Northwestern Mutual Life Insurance Company. He had retired from active practice several years ago. The doctor is survived by his wife, a daughter, and two sons.

Dr. John Charles Zuercher, a Milwaukee physician for twenty-eight years, died at a hospital in Rochester, Minn., on March 16. He was 64 years old.

Born in Monroe on April 29, 1885, Doctor Zuercher attended St. Louis University School of Medicine, graduating in 1912. Following internship at La Crosse, he practiced in that city until entering military service during World War I. At the end of the war he took postgraduate studies in Vienna, Austria. He returned in 1921 to establish a practice in Milwaukee, where he served on the staffs of St. Joseph's, St. Michael's, Milwaukee Children's, and Columbia hospitals. He also served in the child welfare division of the Milwaukee Health Department.

The doctor was a member of the Milwaukee Academy of Medicine, the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by two sisters and four brothers.

Dr. James W. Pegram, a physician in Milwaukee for forty-seven years, died at a Milwaukee hospital on March 21. He was 69 years old.

A native of Tuscumbia, Alabama, Doctor Pegram was born on April 24, 1880. He received his medical degree from the Univerity of Virginia Department of Medicine, Charlottesville, Va., in 1902, establishing his practice in Milwaukee shortly afterward.

The doctor was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by a brother and a sister.

Dr. John O. Dieterle, widely known orthopedic surgeon from Milwaukee, was found dead at his cottage near Minocqua on March 21. Death was pronounced due to a coronary occlusion. The doctor was 57 years old.

Born at Portsmouth, Ohio, on April 19, 1892, Doctor Dieterle was graduated from the University of Michigan Medical School. He began practice at Dollar Bay, Michigan, in 1917, moving to Milwaukee in 1920. In 1927 he took postgraduate studies in orthopedic surgery in England, France, Germany, and Austria. He was on the staffs of Milwaukee and St. Luke's hospitals.

A diplomate of the American Board of Orthopedic Surgery, the doctor was a fellow of the American College of Surgeons. He held membership in the Milwaukee Academy of Medicine, American Academy of Orthopedic Surgeons, Clinical Orthopedic Society, Medical Society of Milwaukee County, State Medical Society, and American Medical Association.

Survivors include his wife, a son, and a daughter.

Dr. N. C. Schlossmann, Waukesha physician, was found dead in his office in that city on March 15. The doctor was 36 years old.

A native of Waukesha, the doctor was born on March 1, 1914. He received his degree in medicine from the University of Wisconsin Medical School in 1937, following which he became a house surgeon at Michael Reese Hospital, Chicago. Later he was a resident physician and research assistant at Mount Sinai Hospital, New York, and did a year's work in urology at the New York Post-Graduate Hospital before returning to Waukesha in 1942. He served on the staff of the Waukesha Memorial Hospital.

The doctor was a member of the Waukesha County Medical Society, the State Medical Society, and the American Medical Association. He was a fellow in the International College of Surgeons.

Survivors include his wife, his parents, and three daughters.

EXAMINERS IN BASIC SCIENCES SCHEDULE EXAMINATIONS

The next two examinations of the Wisconsin State Board of Examiners in the Basic Sciences have been scheduled as follows:

June 3: 8 a. m. to 5 p. m. at the Plankinton House, Milwaukee. The last filing date is May 27.

September 30: 8 a. m. to 5 p. m. at the Assembly Chamber, State Capitol, Madison. The last filing date is September 23.

Applications should be directed to Professor W. H. Barber, Secretary, State Board of Examiners in the Basic Sciences, Ripon College, Ripon, Wisconsin.

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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Queries and Answers

an intermittent column, which contains some of the questions asked of the State Medical Society and its answers

Editor's Note: This service is provided only in general terms and on questions affecting the interest of the entire profession.

The letter presents related questions of general interest to members of the State Medical Society. You stated that Physician A, who does not have hospital privileges, admitted a patient under the name of Physician B, whom A was utilizing as a consultant. The patient in question was therefore admitted under the name of Physician B. The patient was in coma and the family, because of religious beliefs, refused to permit treatment.

You have requested an opinion on the following questions:

1. What is the responsibility of Physician B under the above circumstances?
2. Can Physician B institute treatment to the best of his judgment without the family's consent?
3. Can Physician B refuse to manage the case even after the patient has been admitted to the hospital under his name?

In answer to question 1, it is our opinion that Physician B has no legal responsibility to the patient. This opinion is based upon the two assumptions that you have reference to legal rather than ethical responsibility, and that Physician B is not an employee of the hospital. A physician is under no legal obligation to render professional services to anyone who applies to him or seeks to engage him. It is not until he has agreed to render professional services that the relationship of physician and patient is created with its attendant duties and obligations. Under the facts you present, Physician B has not undertaken the treatment of the patient, and the mere fact that the latter was admitted under the name of Physician B is not adequate to establish a physician-patient relationship, and with it a consequent legal responsibility.

The answer to question 2 presents a number of difficulties which will, in any event, require varying assumptions of fact. If the patient was under 21 years of age and was unmarried, his parents have the right to refuse permission to Physician B to give treatment. In such a situation Physician B would render treatment at his own legal risk.

If the patient was over 21 years of age and not mentally competent, permission to treat could be given only by his guardian. If the guardian did not happen to be one of the parents, the objecting parent or parents could be disregarded, as could brothers, sisters, spouse or children.

If the patient was over 21 years of age, or an emancipated minor, was mentally competent, was unmarried, was conscious at the time he saw Physician A, and requested Physician A to treat him or to arrange treatment for him, Physician B would have sufficient authorization for treatment to proceed even against the wishes of the patient's parents, brothers or sisters. Assuming the patient were married, but that the facts were otherwise as above stated, Physician B could proceed safely despite the objections of the spouse or of any children.

Assuming the patient were over 21, competent, but in a coma at the time he was seen by Physician A, there is obviously no possibility of the establishment of a direct patient-physician relationship during the continuation of the coma. In such a situation a contract is implied in law between patient and physician to the extent of essential professional treatment. If Physician A chose to substitute Physician B in such a situation, a contract in law between the patient and Physician B would be implied as fully as if Physician A had remained in charge of the case. Thus, Physician B may institute treatment to the best of his judgment without the consent of such patient's parents, brothers, sisters, spouse or children.

The above assumptions do not exhaust the possibilities but are believed to represent the major situations which might arise. In an effort to indicate the legal position of Physician B under varying circumstances, the law has been somewhat oversimplified in certain cases, but is believed to be essentially correct. Generalization, as you know, is possible only at the risk of some inaccuracy. Here we should need more facts than have been furnished to give you a completely satisfactory opinion on the institution of treatment by Physician B.

Question 3, as to whether Physician B can refuse to manage the case under the assumed facts, is answered in the affirmative for reasons indicated in the above paragraph dealing with question 1.

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Liver & Biliary Diseases, One Week, starting June 5.
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CORRESPONDENCE

EDITOR'S NOTE: The following excerpt from one of the county secretaries is printed without identification. It emphasizes a problem many of us are prone to overlook. Are there others who have a similar problem?

Dear Sir: I read your letter, regarding the invitation of the officials of the State Society to our meetings, to the assembled society. We would be greatly honored, of course, to have any of these gentlemen meet with us. The reason we have been rather lax in this respect lies in the fact that we have but four meetings a year. The president and secretary call the meeting when preparations and speaker have been assured. This allows flexibility, necessary in the past, to accommodate the available time of guest speakers. The members of our relatively small and isolated society, consisting entirely of general practitioners, express the desire for speakers who can add to our professional knowledge and skill. I regret to admit that too few of them avail themselves of the clinics which the State Society and other organizations have made available from time to time. Perhaps there might be an increase in the number of these clinics, especially of more interest to the general practitioner and rural physician than the previous run of cancer and industrial clinics has been. To more than half of our members the four county meetings a year are the only postgraduate lectures they avail themselves of. Therefore, important as the machinery and politics of the state and national society may be, especially at the present with the "Welfare State" threatening us, these rural physicians feel that they can do a better job of public relations by attending their patients as diligently as possible, and even give this diligence as the reason they can not leave their practice for lectures at more distant points. These are not necessarily my opinions but I have had myself to battle the unfavorable comment of my patients every time I absent myself for a postgraduate session. To these simple people, our patients, the availability of their physician when they need him is the main problem confronting them. This problem is not so acute in the cities, though even there the much emphasized doctor-patient relationship gets a tremendous jolt if the doctor they engage one day is not available the next due to the very necessary attendance of a postgraduate lecture, usually in another city. I reiterate that this is not my opinion of the situation but is as it is presented to me by my patients and by some of my colleagues. On the contrary, I feel that more and better organized postgraduate work is necessary if we are to keep up with the tremendous changes being made, especially in the field of therapeutics. Therefore, in this respect perhaps something could be done to educate the public, especially in rural areas, that when their physician is absent attending a state or national meeting or a postgraduate session he is doing it in the interest of being of greater service to the people and seldom is he on a spree or vacation. At the present time in our community all of the educational pamphlets put out by the organization of Whitaker and Baxter fall on deaf ears whenever a physician is out of town for any reason whatsoever.

I have written at greater length than I had intended when I started this letter but it seemed an excellent opportunity to convey some of the ideas expressed which perhaps seldom reach the ears of those in less intimate contact with the "grass roots."

Sincerely,

(Name withheld)

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The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal* "Bookshelf," are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Clinical Management of Varicose Veins. By David Woolfolk Barrow, M.D., with a foreword by Arther W. Allen, M.D. New York, Paul B. Hoeber, Inc., 1948. Price $5.00.

This relatively concise monograph on varicose veins has much to commend it. Most texts covering this subject often lead students and surgeons to considerable confusion by introducing innumerable tests and their modifications. Contradictory anatomic findings are deleted and are replaced by the basic and fundamental anatomic findings which are clarified by excellent photographs, drawings, and case histories. The maze of tests usually described have been reduced to a few which aid the surgeon in determining the extent and type of treatment necessary. The three common methods of treatment are discussed adequately. The reviewer has had but little experience with stripping and, therefore, is in no position to pass on the efficacy of this approach. He is in complete agreement with the ligation method and its possible expected results.

The reviewer recommends this book for anyone interested in varicose veins.—A.R.C.

Psychiatry in Nursing. By Raymond Headlee, M. A. (Psychology), M.D., Milwaukee Sanitarium, Wauwatosa, Wisconsin, and Bonnie Wells Corey, R.N., B.S.N.E., Assistant Neuropsychiatric Nursing Specialist, Veterans Administration. New York, Rinehart and Company Inc., 1949.

This book very well fulfills the author's original goal as stated in the preface. The student nurse is treated as a mature individual; she is encouraged to think in terms of the problems of her patients and to understand, or at least intelligently apply, the principles and practices of psychiatric nursing. The method is a combination of descriptive and dynamic psychiatry, with the emphasis on the latter type. Out of this should develop a better understanding of the general medical patient by the nurse as well as provision for more intelligent avenues of approach to the mentally ill.

Structurally, the book is divided into three sections. Section 1 discusses normal variations in human behavior and uses, as examples of the authors' approach, the problems of sexual adjustment, pain, and sleep. The chapter on sexual adjustment is particularly well presented, with the idea in mind that all too frequently the subject is neglected in the training of nurses. The discussion of the dynamisms is short but effective because the authors relate examples of use to the nurse herself. In fact, they maintain this excellent policy throughout the book.

Section 2 deals with the varieties of mental illness. The discussion starts with mental diseases having demonstrable structural pathology. This, of course, is consistent with the educational precept that the learner proceeds from the known to the unknown. The student should be able to correlate past knowledge and present with less fear and greater ease. Part B of section 2 concerns itself with the affective or "functional" disturbances. The material is presented somewhat contrary to tradition, but it is thought provoking and interesting.

Section 3, the "Practice of Psychiatic Nursing," gives some positive solutions to nursing problems encountered. Perhaps, it could be more inclusive if the book is to be used as a text. However, in most of the procedures discussed the authors assume they are dealing with a reasoning individual. "Common sense" seems to be the keynote.

A very interesting section is appended with brief discussions on "study hints" and case studies. The reference reading list seems extremely adequate and should be stimulating for the instructor.

The book has definite merits as a text because the approach is different and thought provoking—E. S.

The Medical Clinics of North America. Philadelphia Number. Philadelphia and London, W. B. Saunders Company, 1949.

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Clinic of the Pennsylvania Hospital, and a second symposium on nutritional disorders from the Philadelphia General Hospital.

The chapter on venous thrombosis and its complications is a very adequate treatment of the subject and offers a sound guide to the management of these clinical entities. The treatment of acute cardiovascular conditions is well outlined, lacking completeness only in the omission of specific comment on the management of acute coronary insufficiency and coronary occlusion with myocardial infarction. The chapter on diabetic coma is noteworthy for its emphasis on the usefulness of serial electrocardiograms in the diagnosis of hypopotassemia as well as pointing out the availability of a simple test for determination of plasma acetone. The management of massive gastrointestinal hemorrhage is very adequately handled. The value of determination of blood volume and plasma volume is particularly stressed. The treatment of headache as an emergency complaint would have been enhanced by specific comment on tension headache. The section on severe intractible asthma should be useful and the presentation on medical pulmonary emergencies is very well done.

The second symposium on nutritional disorders includes chapters on the dietary management of heart disease, particularly congestive cardiac failure, cardiovascular manifestations of the beriberi, the nutritional aspects of liver injury, and an excellent discussion of sprue. These are all well written, concise and without superfluities. The chapter on the clinical administration of vitamin K is particularly successful. The final two chapters on the inter-relation of nutrient factors and the recent advances in nutrition point up the far-reaching implications of the more recent developments in this field.—A.B.W.

Note: Error in Aminopterin dosage, page 1722. The recommended dose should read 0.5 to 1.0 mg. per day intramuscularly rather than 0.5 to 1.0 Gm. per day intramuscularly.

Medicine Throughout Antiquity. By Benjamin Lee Gordon, M.D., Member, American Association of the History of Medicine and American Academy of Ophthalmology and Otolaryngology; Certified by American Board of Ophthalmology; Attending Ophthalmologist to Shore Memorial Hospital, Somers Point, New Jersey, and to Atlantic County Hospital for Tuberculous Diseases and Atlantic County Hospital for Mental Diseases, Northfield, New Jersey; Authorized Medical Examiner for Civil Aeronautics Administration, Department of Commerce, Washington, D. C.; Author of "The Romance of Medicine." Pp. 840, with 157 illustrations. Philadelphia, F. A. Davis Company, Publishers, 1949. Price $6.00.

The author has faithfully and industriously compiled data on the medicine of prehistoric people, of the Assyro-Babylonians, Egyptians, Ancient Hebrews, Hindus, Chinese, Japanese, Greeks, Romans, and Talmudic Jews. The first 90 pages are filled with irrelevant data on evolution and paleontology. Except for the 70 pages on Talmudic medicine the

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book contains almost nothing that cannot be found in a more critical and elegant presentation in standard medical histories like Garrison or Neuburger. As the author pays little attention to more recent research and discoveries in the field, he maintains opinions which cannot be longer upheld (like the authorship of Hippocrates in regard to the Hippocratic writings). Among the numerous illustrations many are substandard, and most references to foreign authors and books are mutilated beyond recognition.—E.H.A.

Geriatric Medicine; The Care of the Aging and the Aged. Edited by Edward J. Stieglitz, M.D. F.A.C.P., Attending Internist, Suburban Hospital, Bethesda, Maryland; Doctor's Hospital, Washington, D. C. Second edition. Pp. 773 with 180 figures. Philadelphia and London, W. B. Saunders Company, 1949. Price $12.00.

The second edition of this book continues as a reference work, useful perhaps for the practitioner who sees an uncommonly high percentage of older patients. The reviewer would not recommend it as a routine addition to one's private library for several reasons. There is little information given that is not already available in standard textbooks of medicine; there is little new, and, to discover this, the reader has to wade through pages devoted to generalities. This latter criticism is especially true of the first section of the book, with the exception of the chapter on physical therapy.—E.C.A.

Nutrition and Diet in Health and Disease. By James S. McLester, M.D., Professor of Medicine University of Alabama, Birmingham. Fifth Edition. Pp. 800. Philadelphia and London, W. B. Saunders Company, 1949. Price $9.00.

This new edition brings up to date much of the information contained in previous volumes, so that the book will continue to serve as a standard reference in this field. Practitioners will find it eminently useful for this purpose. The reviewer doubts that anyone would have the perseverance to sit down and read it from cover to cover.—E.C.A.

REPORT OF THE ANESTHESIA STUDY COMMISSION

(Continued from page 308)

Further Comment

This patient was a very poor risk, and could not tolerate even a slight reduction of oxygen for any length of time. At the instant of respiratory arrest and suspected cardiac arrest, vigorous artificial ventilation with oxygen must be started immediately. It is seconds, not minutes, which determine the success or failure of resuscitative efforts after circumstances such as these. Quite often vigorous ventilation with oxygen is the only measure needed. However, if the color remains poor and the circulation obviously inadequate or nonexistent, artificial circulation must be considered and promptly provided.

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Coming Events

Industrial Physicians to Convene in Chicago

The American Association of Industrial Physicians and Surgeons will hold its convention in Chicago April 24–28, with headquarters at the Hotel Sherman. Hospital clinics will be held at Wesley Memorial, St. Luke's, and Cook County hospitals and there will be plant tours, scientific addresses, and exhibits in the convention program.

Reservations should be made directly with the Hotel Sherman, Chicago 1, Illinois. Physicians should state their connection with the Association in making reservations.

American College of Chest Physicians Schedules Examinations

The Board of Examiners of the American College of Chest Physicians has announced that the next oral and written examinations for fellowship will be held in San Francisco on June 22. Candidates who would like to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois. Dr. Alfred A. Busse, Jefferson, serves as the governor of the college for the state of Wisconsin, and Dr. Andrew L. Banyai, Milwaukee, is the regent for the district. Dr. Carl O. Schaefer, Racine, is president of the Wisconsin chapter.

The sixteenth annual meeting of the College will be held at the St. Francis Hotel, San Francisco, June 22–25.

Michigan Group to Present Institute on Living in the Later Years

The Institute for Human Adjustment, in cooperation with the Extension Service of the University of Michigan, has recently announced that the third annual Institute on Living in the Later Years will be held in Ann Arbor, Mich., on June 28–30. The program will be centered around mental health problems, medical problems, and education of an aging population. Special features will consist of a demonstration of an activities center for older people and organized discussion groups on subjects including psychologic aspects of medical practice with older people, the role of the local department of adult education with reference to aging and education's contributions to the adjustment of the older person.

Persons interested in attending the institute should write to the University of Michigan Extension Service, 4524 Administration Building, Ann Arbor, Michigan, for further information.

American College of Physicians Prepares Course in Endocrinology

A postgraduate course in endocrinology sponsored by the University of Illinois College of Medicine and the American College of Physicians will be presented at the La Salle Hotel, Chicago, May 15–20. Dr. W. O. Thompson is the director of the course. Registration will be limited to 100, with a minimum of 50. The course will provide an intensive review of recent developments in the field of endocrinology, including endocrine gynecology and sterility. The staff will consist of teachers from the United States and Canada, and there will be presentation of patients during the last hour of each afternoon session. Reservations should be made with the La Salle Hotel, La Salle at Madison Street, Chicago.

Society for Study of Sterility to Meet in June

The sixth annual conference of the American Society for the Study of Sterility will be held at the Sir Francis Drake Hotel, San Francisco, June 24 and 25. The registration fee for the two day session is $10, and physicians are advised to make advance reservations because seating capacity is limited. Hotel reservations may be obtained only through the American Medical Association Hotel Reservations Bureau, which will also make reservations for the American Medical Association convention, June 26–30.

Applications for registration and further details concerning the program should be addressed to the American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield 3, Massachusetts.

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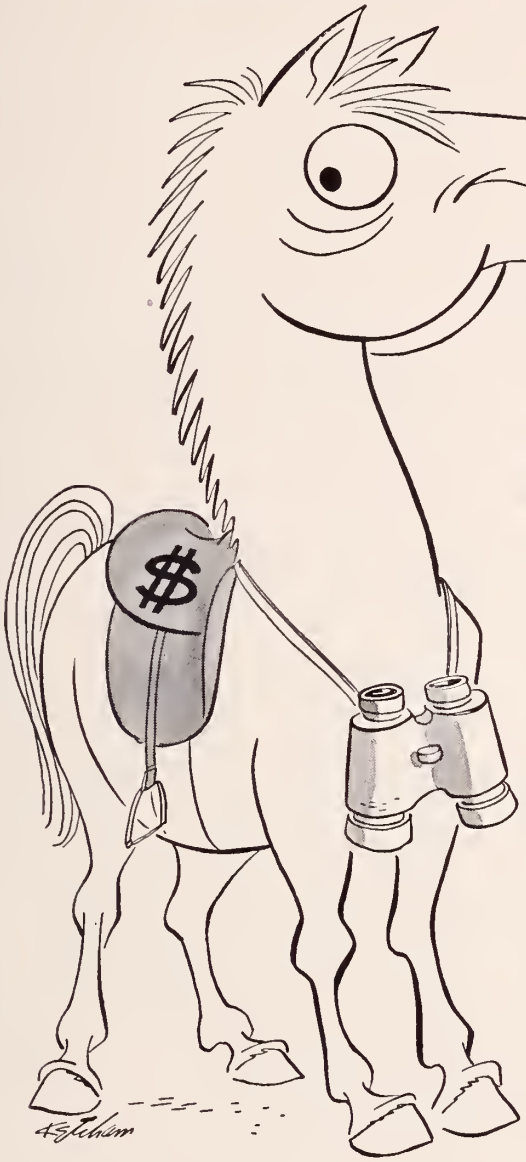

MY FRIEND and I were picking the ponies one day when I started telling him about *a sure thing* I heard about.

"You say it pays four bucks for every three?" he asked.

"Yep," I replied.

"And can't lose? It *automatically* wins? Must be illegal!"

"Not a bit," I replied. "In fact, the government very much approves . . ."

"Our government approves of a horse who can't lose . . ."

"Who said anything about a horse?" I asked.

"So what else could it be but a horse . . .?"

"It not only could be—but is—U. S. Savings Bonds," was my prompt reply. "The surest thing running on any track today.

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"Tearing up my racing form! The horse I'm betting on from now on is U. S. Savings Bonds."

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: Physician to work as associate in general practice on liberal initial salary on a percentage basis, the latter to be increased by agreement of both parties so that in 5 years income would be equal. Municipal hospital facilities available, in college town of 5,000. New office expected by fall. Temporary association also agreeable if desired. Address replies to No. 299 in care of the Journal.

FOR SALE: Ophthalmologist-otolaryngologist wishes to sell forty year old established practice located in an industrial area of Milwaukee. Doctor agrees to work with buyer until business is secure. Address replies to No. 283 in care of the Journal.

AVAILABLE: Radiologist, aged 31, Wisconsin license. Eligible for Boards in both diagnosis and therapy. Completing three-year training in large teaching institution. Available July 1, 1950. Address replies to No. 279 in care of the Journal.

FOR SALE: General electric portable shockproof x-ray unit in excellent condition at ⅓ of list price. One new mobile 30 MA, 96 PKV, Fischer shockproof x-ray unit at $795. One new Fischer short wave with hinged drum electrode and arm, FCC type approved, $355. One used Jones metabolism unit guaranteed accurate at one-half price. One new style Hyfrecator used only a few months, at marked reduction. One used direct writing electrocardiograph at about one-half price, factory reconditioned. C. C. Remington, 720 North Jefferson Street, Milwaukee 2. Telephones Daly 8-6368 and Woodruff 2-4028.

FOR SALE: Practice of deceased physician, including supplies and office furniture in village of 1,000 in center of rich agricultural district. Address replies to No. 285 in care of the Journal.

FOR SALE OR LEASE, or will employ with option of buying: Well established E. E. N. T. practice in Milwaukee. Refraction constitutes large portion of income. Address replies to No. 286 in care of the Journal.

PHYSICIAN AVAILABLE: Desire to associate with doctor or clinic in Milwaukee for evening office work. Trained in internal medicine. Call Dr. J. E. Gruender, Hilltop 5-6089.

WANTED: Physician as associate with two other doctors in city of about 5,000 in east central Wisconsin. Fine hospital. Excellent opportunity. Address replies to No. 287 in care of the Journal.

ENTIRE HOSPITAL CONTENTS FOR SALE: At one-half price, all A-1 condition; *(a)* 11 beds, mattresses, gowns, bedpans, kitchen equipment, dishes utensils, catgut, 4 bassinettes, all of general hospital equipment line $3,000 worth for $1,500; *(b)* operating table, obstetric table, surgical instrument table, operating light, for $500; *(c)* surgical instruments, ample for four major surgicals per forenoon, value $8,000 A-I condition, good as new, obtainable for $5,000. Must be purchased as entities to consummate sale at these figures; total price for entire lot, a, b, and c, if taken, $6,500 cash, otherwise, as listed above; a real value to replace your stock equipment or for beginning your own hospital. Address replies to No. 295 in care of the Journal.

PHYSICIAN WANTED: Internist or general practitioner willing to do mostly internal medicine. Join group consisting of obstetrician, pediatrician and dentist in Milwaukee suburb. Veteran preference. Address replies to No. 297 in care of the Journal.

AVAILABLE IMMEDIATELY: Large general practice in town of 1,300 about 15 miles from Green Bay. Office includes large waiting room, two examining rooms, drug room and laboratory and small room for files, etc. Also x-ray machine and large stock of drugs. Hospital facilities and staff connections available. Practice should gross $16,000 first year. Also, a four bedroom house for immediate occupancy. Address replies to No. 298 in care of the Journal.

FOR SALE: Country practice in northwest Wisconsin. No competition. Modern residence, ideally located. Annual dairy income in territory. Nothing to buy but five room residence, with office room, waiting room, and laboratory in residence. Separate parking and sidewalk to waiting room. Spacious lawn, foliage, and ideal residence. Young man can use extra rooms for hospital rooms. Selling reason: coronary thrombosis. Address replies to No. 170 in care of the Journal.

WANTED TO BUY: Tilt table for proctoscopic examinations. John A. Tasche, M. D., 809 North Eighth Street, Sheboygan, Wisconsin.

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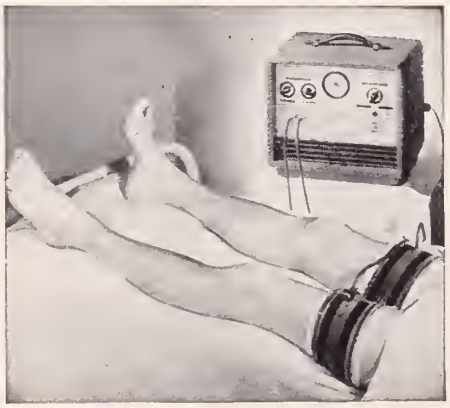

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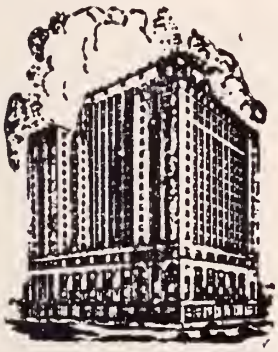

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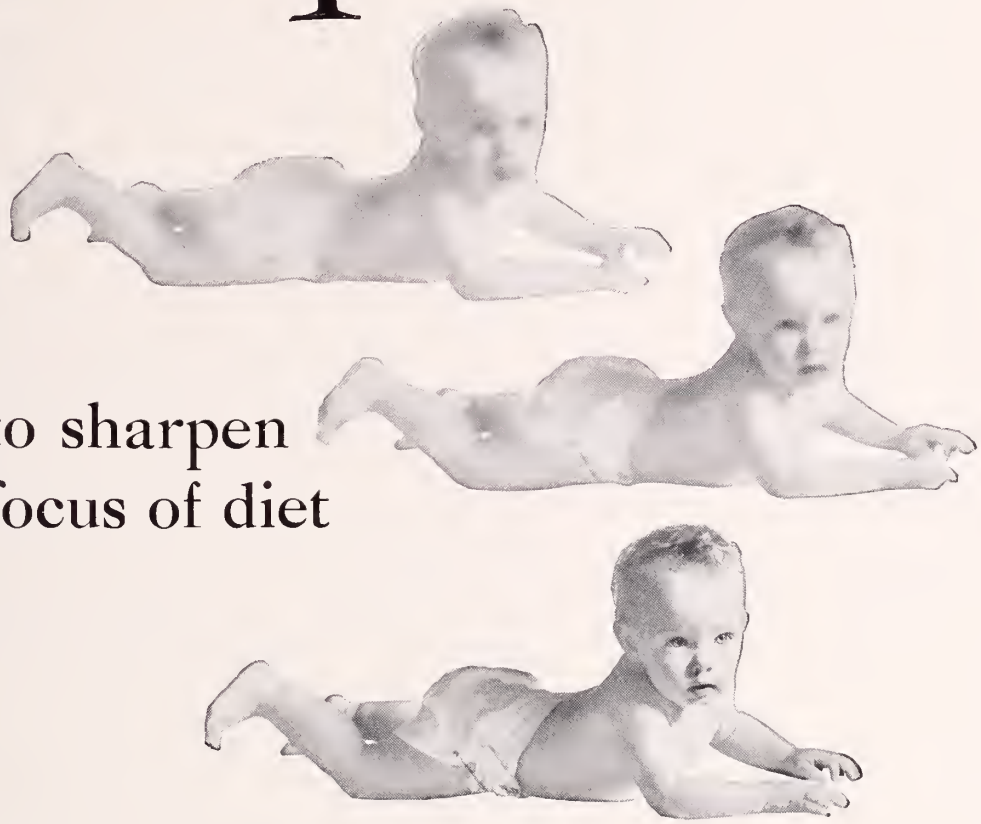

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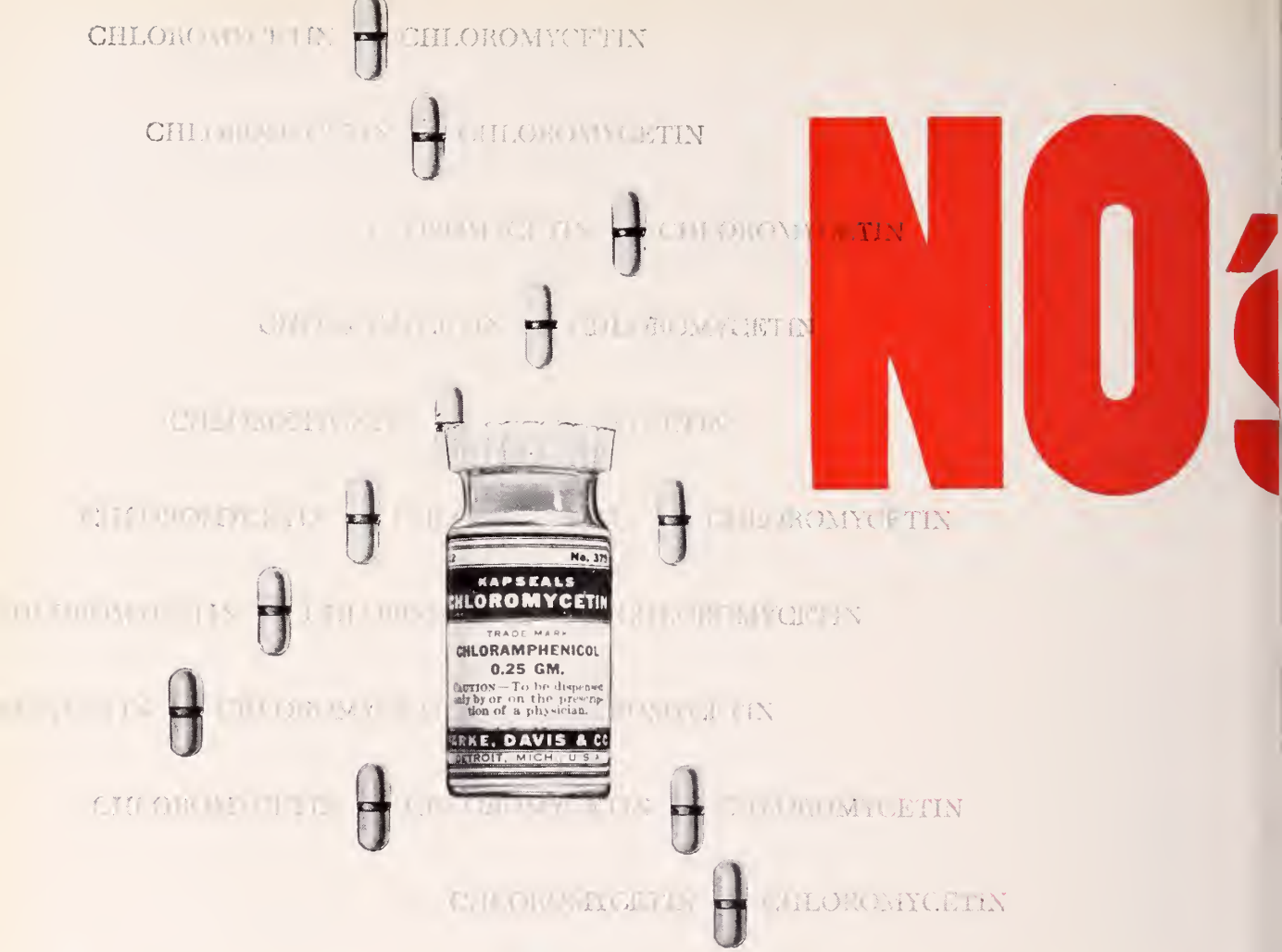

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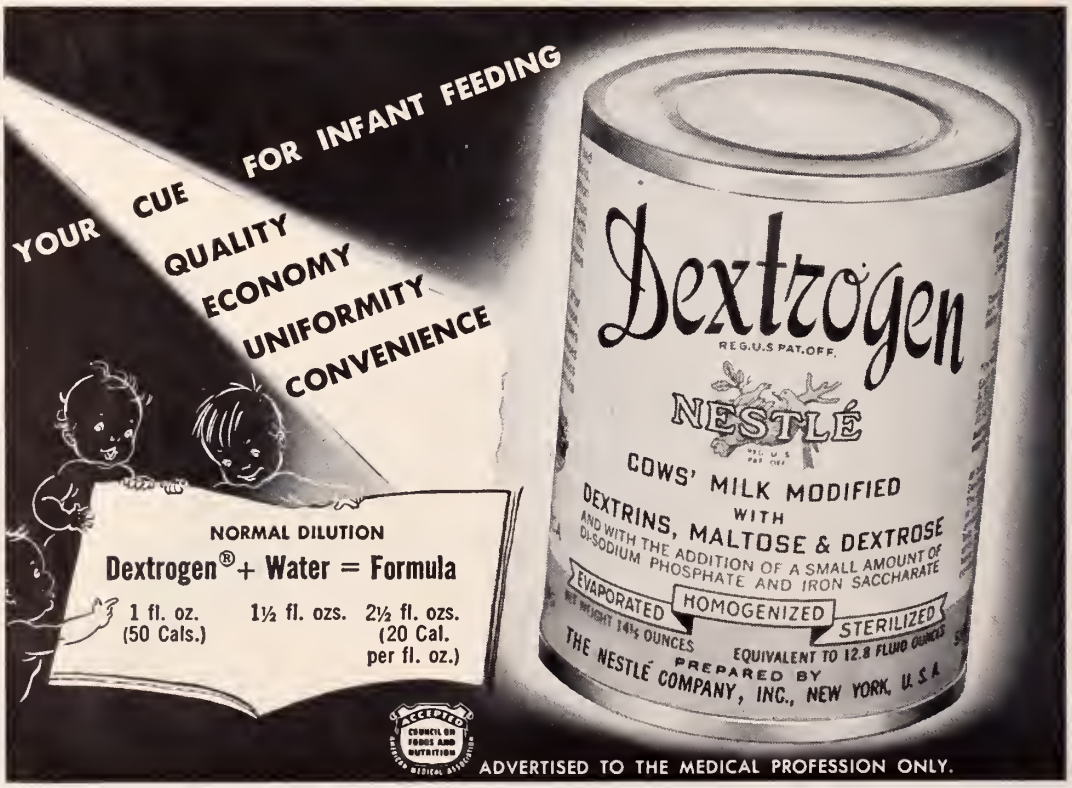

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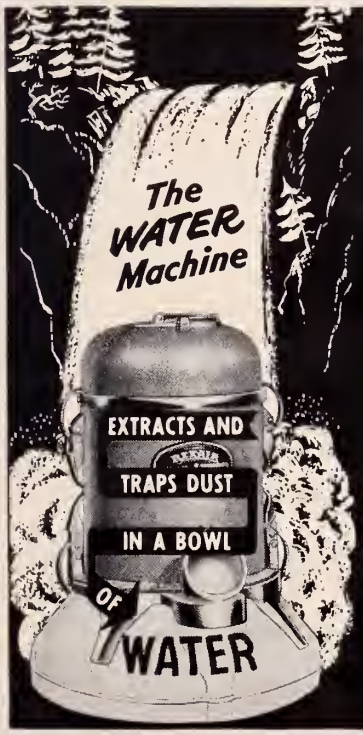

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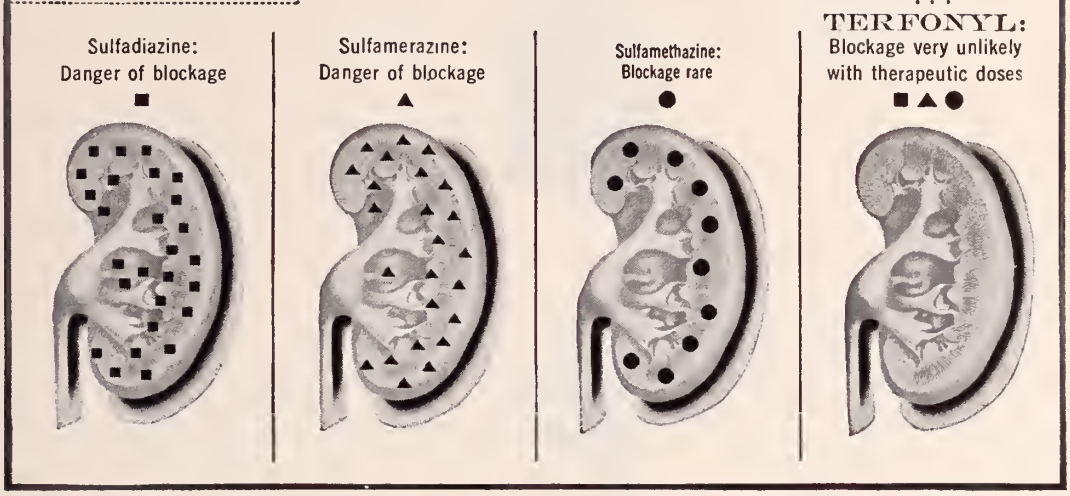

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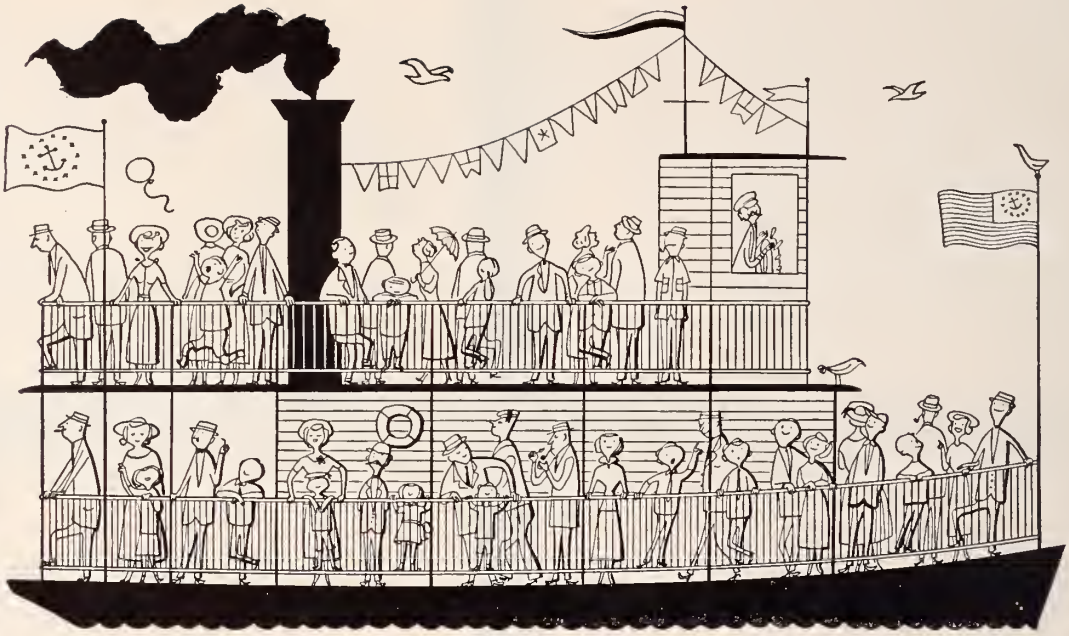

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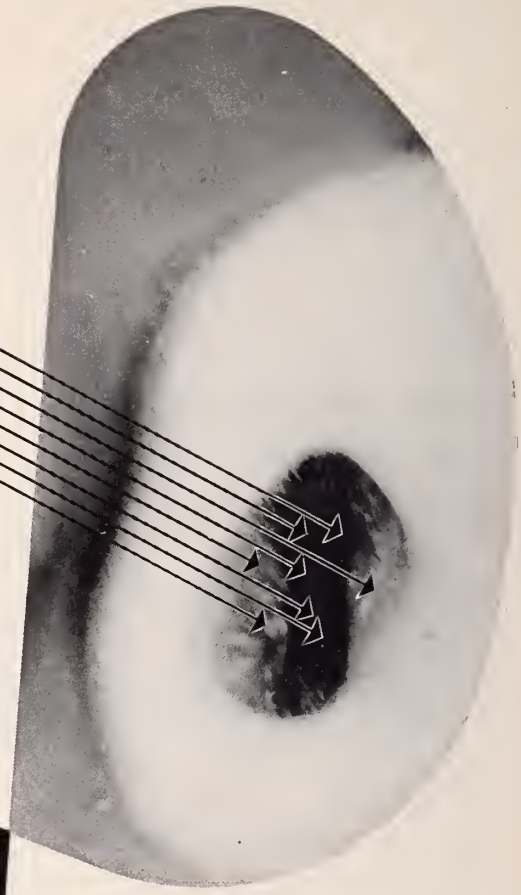

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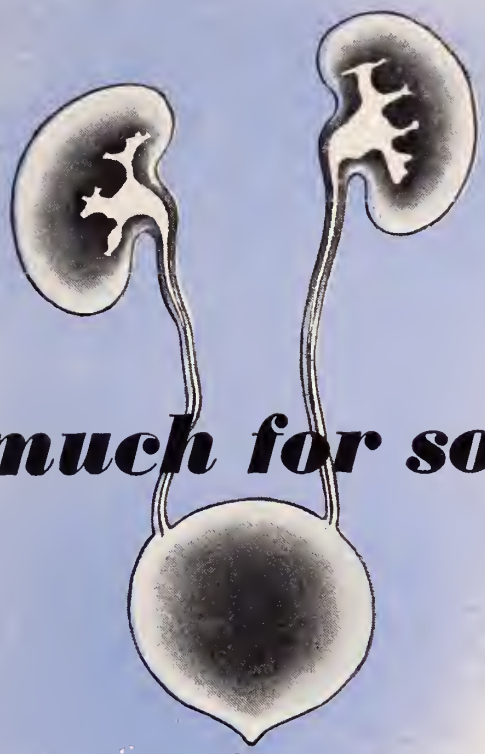

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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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Volume 49 MAY, 1950 Number 5

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« « « EDITORIALS » » »

Estrogens and Cancer

The role of estrogens in carcinogenesis in the human female is a moot question. Well known and reliable investigators are of opposite opinions. There are only a few reported cases in which carcinoma of the breast, cervix, or corpus endometrium has occurred in women following estrogen therapy. Since many patients have received prolonged therapy without this sequel, and since innumerable women have died of cancer without receiving estrogen therapy, the significance of the small number of reported cases of cancer following estrogen therapy is open to question.

It is true that in laboratory animals, the mouse has been the only one in which cancer of the uterus has developed following the administration of estrogens. This has not been duplicated in other species, such as the guinea pig or monkey, in spite of repeated and large doses of the hormone. Also of interest is the time required, one tenth to two thirds of the animal's life span, to produce cancer in the mouse. This corresponds to a period of seven to ten or more years in the human life span.

It is perhaps unfortunate that we have to base our knowledge of the relation of carcinogenesis to estrogens on laboratory animals. However, the mouse, for experimental purposes, is an excellent animal, since spontaneous development of cancer of the uterus has never been noted in this species. Estrogenic carcinogenesis in mice, while evidence of the influence of this hormone on the uterus of this animal, is not evidence that the human female will be similarly influenced.

It has been felt by some that postmenopausal endometrial hyperplasia in the human female is to be regarded as a precancerous lesion. Emil Novak, Howard Taylor, and many others favor this concept, while Jones and Brewer, Fluhman, Franklin Payne, and others insist that the association is no more than accidental. Jones and Brewer, in a study of 68 patients with corpus cancer, found only 2 with cystic hyperplasia and concluded there was no evidence for the unopposed action of estrogen in producing endometrial carcinoma.

While this controversy continues, another group of cases is being reported which may constitute the most important evidence for an estrogen factor in endometrial cancer. These belong to an ever increasing group of patients in which the associ-

ation of granulosal cell and theca cell tumors of the ovary, and adenocarcinoma of the endometrium has been observed. In view of the relative rarity of these tumors and the high percentage incidence of this combination (21 per cent, Dockerty), it is not likely that this is accidental. With the estrogen-producing capacity of the granulosal and thecal cell tumors in mind, the probable sequence of hyperestrinism, hyperplasia of the senile endometrium, and finally cancer, in at least this special group, demands consideration. Further evidence is accumulating that the essential factor is the continuous estrogenic stimulation without periods of rest afforded by the normal estrus cycle. This is in line with Zondek's idea that extremely large doses of estrogen do not cause uterine cancer and may even prevent it by inhibiting the anterior pituitary gland and by producing a "hormonal castration."

And so the question, "Can estrogen actually produce cancer in the human female?" goes unanswered for the present. However, if there is controversy over the possible carcinogenic action of estrogens there is universal agreement that estrogen may cause irregular and unusual vaginal bleeding. This brings us to the most important single point to be emphasized: all cases of postmenopausal bleeding must be promptly and thoroughly investigated irrespective of estrogen therapy. This means dilatation and curettage in all such cases.

Perhaps the greatest hazard of the therapeutic use of the estrogens is that of producing irregular and postmenopausal bleeding, which inevitably obscures and delays the diagnosis of cancer. It is the tendency to attribute irregular and unusual bleeding in these cases to the estrogens rather than to a possible underlying cancer, that constitutes the greatest danger.—W. F. Hovis, M. D.

Pea Crop and Toxic Insecticides

Wisconsin produces about two thirds of the nation's canned peas and is also one of the major corn-canning states. Pea aphids and the European corn borer are two major enemies of these industries. These pests must be controlled if the industry is to maintain the mass production of these canned foods.

Of the many insecticides in use, some present real hazards to human beings if not handled properly. DDT, tetraethyl pyrophosphate (TEPP), and parathion are three that have come into wide use in recent years. Most of the hazards in the use of these insecticides are to the persons applying the chemical.

DDT has been used with little danger so long as continuous breathing of the spray or dust is avoided, or, in the case of emulsions, contact with the skin is of only short duration.

These chemicals are toxic by the inhibitory actions which they exert on cholinesterase. Cholinesterase is liberated in tissues by nerve impulses, and acts upon acetylcholine with the resulting formation of cholin and acetic acid. Acetylcholin is a strong vasodipressor which accumulates around the ending of cholinergic nerves when cholinestrase is inhibited by TEPP, parathion, and certain other chemicals.

The signs and symptoms of the inhibitory actions of these chemicals are primarily those of marked parasympathetic stimulation. These are marked muscular weakness, and twitching, salivation, mucus secretion, sweating, and lachrymation. The cerebral cortex is also affected and convulsions of the tonic-clonic type may occur.

Dr. R. E. Green's writing in the November 1949, issue of this *Journal* in the section, "Comments on Treatment," has described the method of action of some of the cholinesterase inhibitors, TEPP, and others, and described the treatment. He emphasized the necessity of removing the poison from the stomach and intestinal tract, the removal of mucus from the bronchial tree, artificial respiration with oxygen and described the specific treatment with atropine. He recommended the intravenous administration of 0.5 to 1 mg. of atropine and a repetition of this dose as the symptoms indicate. The patient must be watched closely for twenty-four to forty-eight hours and in the severe cases artificial respiration may be necessary for several hours.

Following an exposure to these insecticides that is heavy enough to cause symptoms, the patient must avoid further exposure until regeneration of blood and tissue cholinesterase is complete. Other organic phosphate insecticides also inactivate cholinesterase. Persons exposed to these become susceptible to parathion and vice versa.

While no fatalities or extreme sicknesses were reported in Wisconsin in 1949, although more than 600,000 pounds of parathion was used in pea aphid control, it is of interest to the physicians to note that carelessness on the part of insecticide users may bring a patient to their offices with acute poisoning.

University of Wisconsin entomologists, canners, and insecticide manufacturing companies have been active in stressing the necessary precautions with the use of parathion and TEPP. Many physicians have been contacted so they will be prepared to diagnose any cases of poisoning occurring in their area and administer the proper treatment without delay.

Spraying usually begins about the latter part of May, in the case of pea aphids, and continues until early in July. The latter part of June and continuing through September constitute the period of corn borer control.

1. Green, R. E.: Poisoning by the organic phosphate insecticides, Wisconsin M. J. 48:1007 (Nov.) 1949.

A Study of Keloids and Related Conditions

By WALLACE MARSHALL, M. D. and WILLIAM SCHADEBERG*
Two Rivers

THE present communication will review what facts have been learned from past researches on the apparently related topics of acne vulgaris, acne rosacea, and keloids. We shall present further data which seem to close the cycle of events present and which produce the disfigurations seen in cases of marked keloids.

This topic assumes a particularly important aspect, for keloids are new growths, or, as some observers state, "pseudo-neoplasms"; if their etiologic mechanisms were known, this knowledge might assist in the study of more complex growths, such as certain forms of cancer. As one of us has written previously, "The logical approach to the study of complex problems, as cancer growths, for instance, should be attacked by attempting to learn something as to the *modus operandi* of benign tumors . . . It appears that we must attempt flying before we have made the plane available."[1]

If one reviews the known mechanisms at work in the production of keloids in the current dermatologic and surgical journals, the answer will be wanting.

Should one review the theories which have been advocated in explaining a benign growth, such as a keloid, the only dominant theory is that of embryonic rests (Cohnheim). However, we have shown previously that fibrous tumors which are very similar to keloids can be produced experimentally in the human being. These can be grown readily by following our technic, to be reviewed later. "It was the body's reaction to injury, and eerie spirits and haunted cells had nothing to do with its result."[1] The theory of embryonic rests does not seem to explain the origin of fibrous tumors, such as keloids. Anyone can readily produce a similar tumor mass if Marshall's technic[2] is followed. This procedure will be reviewed later.

Some years ago, while studying the role of low blood cell counts (anemia) on the production of the neurasthenic syndrome, the authors observed improvement of the skin in a few of the cases which were under study.[3] The patients in these cases had acne vulgaris which improved with therapy consisting of injectable liver extract and a halibut liver oil and malt preparation. Of particular interest was the reduction in the number of comedones. Another paper followed,[4] which demonstrated that the injectable liver extract probably contained a skin factor (S) which seemed to improve the complexions of patients who had acne vulgaris. The halibut liver oil and malt regime was not responsible for the improvement. Furthermore, it was thought that this skin improvement was not dependent upon the rise in the red blood cell counts in such patients.

Then followed some articles in which the authors described studies in order to rule out certain factors in injectable liver extract that appeared to be important in bringing about improvement in cases of acne vulgaris.[5, 6] Later, it was found that boiling the injectable liver extract seemed to enhance its clinical results in these patients with acne.[7] Attention had been called, in the course of these several publications, to the reduction of the seborrheic aspect in these patients with acne. Their faces became far less oily and the comedones became less in number.

Additional study on this topic was helped decidedly by the mental and the physical improvement noted in these patients.[8] Their outlook on life changed from that of hopelessness to a psychologically improved attitude. This was followed by an extensive and detailed study of clinical results with two new preparations obtained from crude liver extract.[9] The summary was: "Results with an experimental liver extract preparation AI–3, on twenty-five unselected cases of acne vulgaris produced a moderate or marked improvement in 68% of the cases. With the use of a further improved medication on 27 unselected cases of acne vulgaris 89% showed a moderate or marked improvement. The material was LYo–6 (Kutapressin). This high incidence of improvement was further checked independently by two well qualified dermatologists who used the LYo–6 material on twenty-three cases of acne vulgaris in their private offices. Eighty-three (83%) of these cases were 'cured' or moderately improved. Seventeen (17%) showed slight improvement, and there were no failures. A drop of three-tenths of a degree in the facial skin temperature was recorded in a *normal* subject after an administration of one cubic centimeter of the experimental material had been given. This took place within a time limit of fifteen minutes. The temperatures were recorded with a thermocouple. This suggested that a vasoconstriction of the skin vessels was taking place, for the complexion of the subject had blanched. The blanched appearance persisted over twenty-four hours. The above phenomenon was found to take place in the acne patients who were under treatment with the experimental material. Current concepts of scar tissue pathology have been discussed with the hope of obtaining knowledge as to how these experimental liver extracts might influence scar formation, for it has been observed that these materials played an important role in the partial scar absorption and

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* Laboratory technician, Two Rivers Community Hospital. We are indebted to Miss Ann Issacson, R.N., superintendent of the above hospital, for the laboratory facilities which were placed at our disposal. This study was supported by a grant from C. O. Miller, Ph.D., president of Kremers–Urban Company, Milwaukee. This firm manufactures Kutapressin, the preparation discussed in this communication.

improvement which was noted clinically in seven patients who had been under constant therapy for seven months to two years with our experimental materials. Their action in three cases of abscess formation is discussed. The beneficial effect of these materials on the menstrual cycles in some of our cases has been mentioned. . ."

Stillians,[10] using one of the above preparations, furnished to him by Prof. Chester Farmer* and myself, observed that, "Marshall's success in treating acne by the subcutaneous injection of boiled liver extract led Lichtenstein and myself to try it in acne in the tuberculous. At the Municipal Tuberculosis Sanatarium in Chicago we have a special acne problem, for these young people are on a fattening diet which we do not venture to change. Our hope was that the liver extract might benefit the pulmonary disease as well as the skin trouble. We saw no definite benefit to the general health but did see improvement of the acne in a fair percentage of cases. We treated 57 cases, with great improvement in 21%, moderate benefit in 19%, slight improvement in another 14%. To our surprise some of our best results were in 2 cases of acne conglobata and in one case of acne in a patient whose general condition grew rapidly worse as her acne improved." These investigators presented these same findings in another article.[11]

I had noted previously[12] that vasoconstriction of wound areas tends to improve healing. Rosenthal and I had reviewed the basic biochemical processes that might be involved in the pathogenesis of keloids.[13] "It was found that tissue fluid exudations, if allowed to remain in the tissue spaces, as the result of injury, attract the fibroblasts which invade the injured area. Later on, the proliferation of scar tissue occurs."[14]

Since it occurred to me that a chemotropic response which resulted in the attraction of fibroblasts to inspissated serum, which might be the "trigger-mechanism" that produces this scar tissue formation, the following sets of experiments were performed. The first, using blood serum, was taken from a "Wassermann-fast" patient. Although this particular serum was three years old and it had been exposed to intense heat and freezing in the interim, it produced a small fibromatous tumor on my right thigh after this material had been injected intradermally repeatedly. The control site, on the opposite thigh, which received similar injections of saline, remained negative. The second investigation employed my own blood serum, and this serum was injected intradermally repeatedly just above the previous experimental site on my right thigh. The control site, on the left thigh, which received similar amounts of saline, remained negative. It was found, upon thorough histologic examinations, that at the site in which my own serum had been injected there developed a larger fibromatous area than there did in the area which received the three year old serum taken from the syphilitic patient. These histopathologic changes demonstrated that these serum injections produced subepithelial changes very similar to those seen in keloids.[2] The same basic pathologic processes were thought to be at least one of the causes for uterine fibroids.[15] Another report[16] stated that this chemotropic response of fibroblasts to inspissated blood serum seems to be specific to the type of animal employed. Blood serum from a different species does not seem to produce a chemotropic response of fibroblasts in the tissue of another animal, and it appeared that only the blood serum of a similar animal initiates fibroblastic changes in the skin tissue. In some animals, such as dogs, there does not appear to be a propensity for development of keloids.

We have stressed, heretofore, that the formation of keloids is but a skin manifestation of the body's reaction to injury. It appears that other identical processes are found in other tissues and organs of the human body as the result of this chemotropic response of fibroblasts to bodily injury.[1, 17]

Recently we have witnessed the relationship of the above remarks to another pathologic process seen at times in routine practice. We have acne rosacea in mind, for Becker and Obermayer[18] have written, "as a result of long protracted rosacea, fibrosis ensues, especially of the nose, which results in slight nasal enlargement. In some cases, a striking enlargement occurs, in the form of a lobulated tumor (rhinophyma)." We have treated several of these patients with the vasoconstricting substance obtained from liver extract. The clinical results were most satisfactory, for a definite shrinking action ensued within a few minutes after the injection was administered. This is very similar to those results described hereto with the treatment in cases of acne vulgaris and in cases of keloidosis.

We have been puzzled as to the reason why some patients seem to possess the questionable ability to have keloids develop. This is true also in certain races of human beings, particularly negroes.

Marked cases of keloidosis are rare, but recently, a patient, 32 years of age, came in for therapy. He gave a history of having had this affliction for a period of fourteen years. This difficulty began following the insertion of a metal wire in a carbuncle on the angle of his jaw fourteen years ago. Shortly afterward, a veritable crop of keloids began to grow on his face, neck, back, and chest. Repeated attempts at the usual forms of therapy produced no results, so that his face, upon entrance, appeared to be similar to the leonine facies one associates with a severely nodular leper. Examination revealed dozens of keloids in the above described areas, which were pedunculated and markedly indurated and which stood away from their bases. A scaly eruption covered the small areas of skin which were not involved. Medical colleagues who have examined this particular patient have expressed amazement at the pronounced and highly numerous keloidal growths which this patient presented.

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* Chairman, department of chemistry, Northwestern University Medical School. Part of this research was done in this institution.

The question arose as to why, if our theory of positive chemotropism (attraction of fibroblasts due to inspissated blood serum in the tissues) was correct, shouldn't this patient show some sort of discoverable change in his blood or blood serum which would explain the reason for his marked keloidosis. An examination of current literature gave no clues as to the cause.

The patient's blood was subjected to a thorough analysis. Every conceivable test was run to give us some clue in order to learn why such a pronounced keloidosis developed in this patient. All tests were within normal limits, with the exception of one test, the albumin-globulin ratio.

According to Harrow,[19] the normal human blood range of albumin is 4.6 to 6.7 mg. per hundred cubic centimeters. Globulin has the range of 1.2 to 2.3 mg. per hundred cubic centimeters. Our patient with the marked keloidosis showed 3.99 mg. per hundred cubic centimeters of albumin and 4.43 mg. per hundred cubic centimeters for globulin. In other words, the albumin-globulin ratio was reversed, and this fact would easily account for the continual presence of the edema of his skin areas in which these marked keloids developed.

Harrow has written that "aside from fibrinogen, which plays a specific role in blood coagulation, the proteins of the blood (and this applies more particularly to the albumin and globulin fractions) maintain the water balance between the blood and tissues. This property is dependent upon the attraction for water which these proteins have. While it is quite true that the osmotic pressure of the plasma proteins is almost negligible when compared with the crystalloids present, nevertheless the latter, unlike the proteins, do not play a role in the distribution of water, due to the fact that they pass freely through the cellular walls. That these proteins—and more particularly the albumin, because it has a smaller molecule and is present in larger quantity—are important in the distribution of water is evident from the fact that patients with a deficient amount of serum albumin suffer from edema. . . Weech has pointed out that edema rarely appears before the albumin is below 2 per cent. Between globulin and edema there is little, if any correlation. . ."

The interesting point is, in spite of this definite reversal of the albumin-globulin ratio (and this test was done after the patient had received daily injections of our injectable liver preparation), his keloidal masses continued to recede with therapy. In other words, in spite of the reversed albumin-globulin ratio and the resultant skin edema, the vasoconstricting action of the medication was powerful enough to cause at least a partial recession of the keloidal masses, which we have observed hereto are not composed of scar tissue entirely. There is a good deal of tissue fluid in these keloids, which, with this therapy, can be made to recede by the vasoconstricting action of the medication.

We have not succeeded in evolving a scientific method for measuring the recession of these keloidal masses. The usual procedure is the "fore and aft" pictures, which, at best, do not really bring out the actual clinical changes as they are actually observed. But we do know that a definite and marked recession of these keloids has occurred, because the patient can now shave easily. The keloidal masses have receded so that his friends and relatives have remarked on the decided improvement. The keloids have shrunk in all diameters and they are now supple, whereas previously they were markedly indurated, hyperemic, and most prominent. Truthfully, the entire clinical picture and changes defy adequate description. Perhaps the patient himself is the best judge. He states that he now is able to button his shirt at his neck. Heretofore, these keloidal masses hung from his neck so that he had to leave his shirt collars open, and he covered the disfiguration by the use of a scarf which he wore continually when he left his home. The back and chest keloids have flattened out decidedly, so that these areas are now smooth, white in color, and soft. The scaly eruption disappeared after the first week's treatment. His mental improvement is obvious, for he does not shun the company of friends as he had done for years. His outlook on life has changed markedly for the better, and he seems very eager to receive his daily injections, which he has obtained for the period of a month at this writing.

Mr. S., a white man, aged 49, was seen for the first time Dec. 26, 1949. He gave the history of noting a small pea-sized cyst at the center of the sterum which was extirpated by operation in July 1947. The sutures were removed two weeks later. However, after a short time, he noticed an enlargement in the scar area when the sutures were removed. He was told that this mass would shrink, but it did not. It became larger and began to itch periodically.

Examination by us showed a square-shaped indurated and reddened mass on this patient's sternum. The following data will show the results obtained with the first injection of 1 cc. of Kutapressin. Measurements were performed with calipers.

The keloidal mass had become decidely serrated, smaller, and blanched.

Time	Thickness	Left diagonal Diameter	Right diagonal Diameter	Tranverse Diameter
Before injection	8 mm.	25 mm.	32 mm.	28 mm.
Injection at 11:30 a.m.				
11:42 a.m.	Small white blanched out areas appeared on face of patient.			
11:45 a.m.	6 mm.	Definite ridges appearing in keloidal mass which is becoming lighter in color and much softer to palpation.		
11:47 a.m.		24 mm.	25 mm.	
11:48 a.m.	Shrinking actually noted by members of family who were sitting on opposite side of room.			
11:57 a.m.	5½ mm.	21 mm.	23 mm.	26 mm.
6:30 p.m.	5½ mm.	21 mm.	23 mm.	26 mm.

These same observations have been noted in other patients, so that these findings are not novel. When Kutapressin (the vasoconstricting fraction of liver extract) is made available to the profession, other observers will have the opportunity of studying these same findings.

Summary

From the data presented, it now appears that the present concepts of tumor formation, so far as fibromatous tumors are concerned, should undergo a drastic revision. We have previously produced two separate experimental tumors in the human being, and the site had been selected previously. It is obvious, in the face of this set of experiments, that the theory of tissue rests could not have been the cause for the growth of such tumors, which decidedly resembled keloidal growths. The fact that human serum was employed, and that alone, which produced these new growths, may be ample evidence to discard the theory of embryonic rests.

These keloidal growths have been shown repeatedly to contain tissue serum. This inspissated serum certainly seems to attract fibroblasts which have the tendency to lay down connective tissue which microscopically is fibrous in type.

"Cauliflower ears," often noted in the boxing profession, can be avoided if the ear lobules are freed of the tissue serum which collects in that area as the result of a blow (trauma). If this serum is left intact, there is a distinct tendency in such a patient toward development of "cauliflower ears," which histologically is a form of keloidosis. We have shown previously that keloidal growths contain serum, which, if left in situ, produces a further piling up of fibromatous tissue.

In our recent case of extremely pronounced keloidosis, we have shown that this collection of tissue fluid may have been caused by a reversal in the albumin-globulin ratio. This, in itself, can produce a tissue edema, and the inspissated serum, according to the author's theory of active chemotropism, attracts fibroblasts which lay down fibrous tissue.

In spite of this reversal of the albumin-globulin ratio, the vasoconstricting action of our special liver extract fraction was able to overcome the residual edema which was present in this case for a period of fourteen years. This is, indeed, an interesting phenomenon, since it has been thought heretofore that keloidal formation is an *irreversible reaction*, in that once a keloid develops, nothing can reduce its size except x-ray therapy or surgical treatment. These therapeutic aids, although important, have now been shown to be perhaps secondary when compared to the use of our liver extract fraction (Kutapressin) which is, in itself, nontoxic and which does not produce an increase in blood pressure in patients after many years of clinical observation. Another interesting point is that this material has never produced a sensitizing reaction, which is, at times, noted with the use of most forms of injectable liver extract. Thousands of injections of this material have been administered to patients without the production of any untoward effects in our long series of cases. Many of our patients have received one injection (1 cc. daily) for months without the production of a single untoward effect. This would lead us to the assumption that this material seems to be nontoxic in nature.

The suggestion has been given to give these keloidal patients either the appropriate amount of human albumin to bring the blood albumin up to normal to determine if this procedure would cause a shrinkage of the keloids or, perchance blood albumin is not available for injection, then to administer sufficient blood plasma to alter the albumin-globulin ratio. Since this 1 patient has previously been on a high protein diet without any noticeable shrinkage of his pronounced keloids, this fact seems to answer the above suggestions.

The point has been raised that this patient with marked keloids should have a generalized edema of the body due to the reversal of his albumin-globulin ratio. Since this is not the case, it can be inferred that the permeability of the capillaries in scar tissue may differ from that which is found in normal skin tissues. We have noted, however, that his facial areas, which do not show actual areas of keloidal tissue, have actually become thinner. The patient has volunteered this observation without suggestion. We also noted this observation ourselves as the daily treatments were given. Naturally, there are many phases of this topic which need added study in order to test the theory and the various therapeutic suggestions on acne vulgaris and keloids which we recorded from time to time in the literature.

Our experimental keloids showed a marked blood supply. This was quite evident when these were extirpated. The same pronounced vascular supply was evident in the keloidal growth in our patient, for when these neoplasms were injured, they bled much more profusely than does a wound of the normal skin.

We have, we believe, now been able to present a coherent story as to the origin and the theory of keloidosis which, heretofore, has been enshouded in mystery and unrelated scientific beliefs.

We are also of the opinion that other general practitioners can and will evolve similar therapeutic procedures if they will be given the opportunity for such research. They study each patient in his or her entirety, and they do not approach such studies from the viewpoint of surgery, dermatology, or any other specialty. Hence, their approach is, perhaps, a bit more comprehensive, and this, in itself, should be a boone to the art and the science of medical research, if stipends and grants are made available to those men who do general practice, and who happen to be interested in investigative medicine.

Addenda

Recent studies on our patients with keloids now suggest that keloids *per se* can be regarded as her-

niations of the integument. These were produced in the manner as was described heretofore. It also appears that skin papillomas may be produced by similar mechanisms. Furthermore, our observations have now shown that some keloids when shrunk with Kutapressin change their outer structure so that they resemble papillomas. We take it that the loss of the tissue edema in these keloids may be responsible for this change. We are also of the opinion that keloids have a much wider base of herniation; in that way they differ from papillomas of the skin, which are produced also by more limited herniations of the integument, which in turn, might also be caused by a reversal of the albumin-globulin ratio, which factor seems to produce the tissue edema, the concurrent piling up of fibroblasts, and ultimately the herniation of the skin.

We feel that these skin herniations are identified further by the finding of hair follicles in the protruding skin masses (keloids and papillomas). These follicles are far less numerous than are their members in the nonherniated skin areas. We assume that this was brought about by the stretching of the above protruding skin masses which were produced by the pressure from the tissue edema and the fibroblastic growth from within.

The question arose lately as to whether or not Kutapressin has reversed the albumin-globulin ratio in the patient who formerly exhibited the massive keloids. In order to answer this, a blood study was performed on this patient recently, with the following results: total serum protein 7.2 mg. per hundred cubic centimeters, albumin 3.8 mg., globulin 3.4 mg., and albumin-globulin ratio: 1.1 to 1.

We may prognosticate that, without the further administration of Kutapressin, this patient's keloids might return en masse. The Kutapressin has not affected materially the already reversed albumin-globulin ratio, but in spite of this deranged ratio these keloids have diminished markedly in size with the present therapy.

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AMERICAN PROCTOLOGIC SOCIETY TO MEET IN LOS ANGELES

The forty-ninth annual meeting of the American Proctologic Society will be held at Los Angeles, July 2–5, with headquarters at the Biltmore Hotel. The opening day will consist of registration and a social gathering, and on the remaining three days scientific sessions will be held and selected motion pictures shown. The convention will close with the annual dinner on Wednesday evening.

Admission to the meeting is limited to members and guests sponsored by them. A registration is assessed each one attending the session. Additional information may be obtained from the secretary, Wendell Green, M. D., 201 Professional Building, 1838 Parkwood Avenue, Toledo 2, Ohio.

Analgesia and Anesthesia in Obstetrics*

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ANY discussion concerning the alleviation or control of the pain of childbirth should be introduced with the statement that the time of absolutely painless childbirth has not yet arrived, nor is there any one known method of pain relief which is suitable for every woman in labor. Many technics have been advocated as the best. Today there is no best. As there is no panacea for the relief of the pains of labor, the decision must be made as to which method is appropriate for the individual patient. Each case must be managed according to the surroundings, the available equipment, the ability of the attending accoucheur, and the nervous stability of the patient.

First, let us consider the woman who is going to be delivered by a general practitioner in a private home. This consideration is of paramount importance, as the majority of babies today are delivered by that magnificent band of the medical profession who work under conditions which would be considered adverse by those of us who are specialists. The medical practitioner cannot be expected to follow the same regimen for the relief of pain that the specialist in a modernly equipped maternity ward would. However, relief of the pains of labor may be accomplished in home obstetrics by the judicious use of various drugs. Morphine, scopolamine, small doses of the barbiturates, and rectal ether are the safest and probably the most effective. I should like to call your attention to the fact that chloroform, which has always been the standby of the general practitioner in home obstetrics, should be used extremely carefully because of its action on the liver. If morphine and scopolamine are to be used, they should be used in moderate doses of 1/6 grain of morphine and 1/150 grain of scopolamine. The barbiturates, if given, should not be administered in more than very moderate doses of 1½ to 3 grains, and if the patient has someone in attendance, rectal ether will very often give several hours of much needed, beneficial rest. As a general rule, patients who choose to have their babies at home have a very high threshold of pain endurance. Frequently, the practitioner, upon his arrival in the home, is greeted almost immediately by the lusty cry of a child born of a mother who has had no sedation whatever to relieve her suffering. It is true that the pains of childbirth are quickly and easily forgotten by this class of patients, but, unfortunately, this is not true of the high-strung, unstable debutante of the present age. We have seen many women who have been so mentally disturbed because of the suffering which they endured during their first pregnancy that they absolutely refused attempts at further childbearing. In a few instances in which another pregnancy occurred accidentally, clearcut psychiatric complications developed.

When the patient is to be confined in a poorly equipped hospital or in a hospital where there is a shortage of attendants, great care should be exercised in the selection of a method for the relief of pain. In many of the small hospitals throughout the country, as well as in the private home, the newer forms of pain relief should not be attempted.

In the modern, well equipped maternity department, all forms of analgesia, amnesia, and anesthesia should be available. In the larger maternity wards, a department of anesthesiology should be established, manned by competently trained anesthetists who are capable of administering the various inhalation anesthetics and thoroughly trained in the anatomic approaches to this problem.

Many drugs, too numerous to mention, and many combinations of drugs are used to sedate the maternity patient during the first stage of labor. It has been our experience that no matter what drug or technic or combination of drugs is decided upon, they should not be started until the patient is definitely in labor. So often the early discomforts of labor are misinterpreted as real labor pains and if the analgesia is given too soon, the result is a prolongation of the labor, and failure of the analgesia to continue to be effective during the time when the uterine contractions are most severe. I have selected for brief discussion, those drugs and technics which are most frequently used.

Morphine and Scopolamine

It has been a long time since morphine and scopolamine were first introduced into obstetrics.

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

You are all familiar with the many rash statements which were made as to the fact that women could now have children without suffering pain and probably recall that the lay journals heralded it as the greatest discovery of the age. I believe that a combination of morphine and scopolamine, as first advised, is now used in very few clinics. Many men prefer to use this combination of drugs in smaller doses. In our own clinic we use the combination of morphine and scopolamine very infrequently. The ideal patient to whom morphine should be given is the nulliparous patient who has had an uncomfortable night and in whom, because of rather indefinite contractions of the uterus, labor is not established and rest is most essential. Also, in some cases in which the labor has been ineffectual and in which there is no real dystocia, the sedative effect of morphine and the rest obtained are extremely beneficial to the patient who must of necessity have many more hours of labor. Scopolamine is an excellent drug and, when used in combination with drugs other than morphine, particularly the barbiturates, it blots out the patient's memory very satisfactorily, without particular harm to the baby.

Barbiturates

Following the monumental work of Irving and his co-workers at the Boston Lying-In Hospital, we have used the barbiturates in many thousands of cases. My associates and I have tried practically all of the barbituric acid drugs and their combinations, together with scopolamine and rectal ether. Time does not permit me to go into detail regarding these various combinations, but I can state with certainty that our results have been most satisfactory when the barbiturates have been given judiciously, particularly as to dosage. One of the reasons why this group of drugs has fallen by the wayside is that originally the dosages given were entirely too large. No barbiturate or combination of barbiturates should be used unless the patient is under constant observation and can be restrained not only during the course of labor, but following the patient's return to her room and until the effects of the drugs have completely worn off. If we decide upon this method of sedation for a particular patient, we wait until the labor is definitely established and the cervix is dilated to from 3 to 5 cm. We then give 6 grains of sodium amytal, 3 grains of seconal, and, one-half hour later, 1/150 grain of scopolamine. Thus, we have used a quick acting but quickly eliminated barbiturate in the seconal; a longer acting barbiturate in the amytal; and the scopolamine blots out the remaining islands of memory. If this amount of sedation is not sufficient to carry the patient through the entire first stage of labor, the administration of scopolamine is repeated in doses of 1/300 of a grain. If the effects of this sedation have worn off when the cervix is completely dilated, we very frequently use inhalations of nitrous oxide and oxygen until the vertex is where we can deliver it by outlet forceps. This is accomplished under nitrous oxide and oxygen in an 80–20 mixture and, just before the head is born, the anesthetist floods the patient with 100 per cent oxygen; this is continued until the cord is cut. We do not hasten the cutting of the cord, so that the baby may receive full advantage of the oxygen inhalation. If the sedation has worn off completely, these patients are frequently delivered by either continuous caudal or low spinal anesthesia. We do not like to use this in a patient who is still irrational or too much under the influence of the drugs.

Gwathmey Technic

When Gwathmey introduced his technic for the management of labor, we had fairly good results in a large series of cases. However, after using it over a period of time we did not feel that our results as far as complete amnesia was concerned were as good as when we used it in conjunction with the barbiturates. During the past few years we have limited its use to serving as an adjunct to the barbiturates and scopolamine in those cases of more or less prolonged labor where the original dosage of sedation did not carry the patient through to delivery. I cannot emphasize too strongly, nor mention too frequently, the necessity for this constant observation of the patient under barbiturates or rectal ether. Since we first used the barbiturates we have had only 1 patient meet with harm. This woman, in the absence of a nurse, fell out of bed, and a fractured clavicle was discovered on the day she was discharged from the hospital. We have had several patients get out of bed of their own accord and go to the bathroom a few hours after delivery. These, however, did not suffer any ill effects. This was one method of early ambulation but a trifle too early.

Continuous Caudal Analgesia

In 1942 Hingson and Edwards brought out their technic of continuous caudal analgesia. Because its introduction had met with so much discussion as to the advisability of its use, we approached the use of this method with a great deal of temerity and only after very intensive investigation. Since 1942 we have learned much concerning its use and have decided that it has definitely attained a permanent place in obstetric practice. Our experience has taught us that it is an ideal method of pain relief, particularly in women with upper respiratory infection, cardiac disease, toxemia of pregnancy, and premature labor. To date we have used this method of continuous caudal analgesia in approximately, 4,000 instances, with most satisfactory results. When used for delivery of premature infants, it has been found that the babies all cry immediately and show none of the signs of depression of their respiratory centers.

During the past five years we have employed *low fractional spinal* anesthesia both for the relief of the pains of labor and for terminal delivery. We

believe this to be another outstanding improvement in the control of pain during childbirth. It is certainly the one method in which not one bit of the drug is transferred to the child. Our results with low fractional spinal anesthesia have been just as satisfactory as with continuous caudal analgesia, although our experience with it has not been as extensive as with caudal. At the present time approximately 85 per cent of our patients are delivered by some form of conduction anesthesia even though they received some form of sedative during the early part of their labor. Recently we reported 1,000 consecutive cesarean sections performed with the patient under continuous spinal anesthesia, with one maternal death, which was due to leukemia twelve days following the operation.

Years ago we discontinued the use of spinal anesthesia for cesarean section because of reported deaths, but at that time we were using large doses of rather toxic drugs. We did a great number of our cesarean sections with the patients under local anesthesia, always keeping in mind the fact that babies born after a mother has been deeply anesthetized very frequently have to be resuscitated. With the advent of fractional spinal and continuous caudal analgesia, we again reverted to the use of the anatomic approach and our results have been so gratifying that we only occasionally use an inhalation anesthetic for cesarean section. The patient's smooth convalescence and the excellent condition of the baby immediately after birth are two of the outstanding features of this technic. Many of our patients who have had previous cesarean sections under general anesthesia have commented favorably on the difference of their first few postoperative days following fractional spinal or continuous caudal analgesia. The ability to take food almost immediately, the decrease in abdominal distention, and the absence of nausea and vomiting have aided the patient's convalescence considerably.

Many other methods of pain relief which are being used today are all safe procedures when used in competent hands and the dosage of the drugs such that the baby's life is not endangered.

A few essential points in the selection of any form of analgesia, amnesia, or anesthesia are as follows:

1. Of paramount importance is the careful individualization of the patient as to whether she should be in complete possession of her mental faculties during her delivery or whether she should be anesthetized.

2. The selection of the type of sedation to be used should be based on whether or not the patient has any obstetric or medical complications.

3. When sedative drugs are used the dosage should be such as not to cause depression in either the mother or the child.

4. If amnesic drugs are used, the patient should be under constant observation not only during labor, but until the drug is completely eliminated.

5. Premature babies do not tolerate massive sedation of the mother upon which may be superimposed an inhalation anesthesia for delivery. The occurrence of atelectasis is common in these cases. Premature infants do much better if one of the methods of anatomic approach is used.

6. Continuous caudal analgesia and fractional spinal anesthesia should be attempted only by a skilled anesthetist in cooperation with the obstetrician.

7. Much better results are obtained in mother and child when the anatomic approach to anesthesia is used for cesarean section.

Conclusion

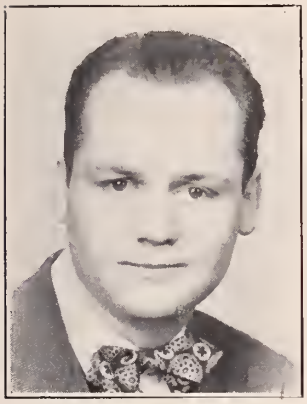
It is our firm belief that, under almost any circumstance, pain relief can be administered in one form or another. However, the type of pain relief selected should be decided upon only after careful consideration of the above points. Many members of the profession have been entirely too enthusiastic about certain types of sedation. Disastrous results will eventually occur where any one type is used as a routine procedure. If care and deliberation are exercised in the management of the parturient patient, a great deal of the suffering of childbirth may be relieved.

AWARD FOR OUTSTANDING RESEARCH IN THE FIELD OF INFERTILITY

The American Society for the Study of Sterility offers an annual award of $1,000—known as the Ortho Award, for an outstanding contribution to the subject of infertility and sterility. Competition is open to those in clinical practice as well as individuals whose work is restricted to research in the basic sciences. Essays submitted for the 1951 contest must be received not later than March 1, 1951. The Prize Essay will appear on the program of the 1951 meeting of the Society. For full particulars, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Mass.

Evisceration

By ALBERT M. KOHN, M. D., and JOHN N. BRIGGS, M. D.
Milwaukee



A. M. KOHN

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J. N. BRIGGS

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BECAUSE of high mortality and prolonged morbidity attendant to evisceration, the literature was studied and, in the light of what has been written, 39 cases occurring at St. Joseph's Hospital, Milwaukee, in the four and one-half year period between October 1, 1943, and April 1, 1948, were reviewed. While the absolute cause of evisceration is unknown, two chief groups of factors are stated to be of prime importance in its pathogenesis. They are increased intra-abdominal pressure and conditions which alter the physiology of wound healing. Analysis of the 39 cases has been made in the light of these factors.

How often does evisceration occur? In the literature it varies from 3.0 to as low as 0.22 per cent, Hartzell in a comprehensive review[16] reporting an average incidence of 1.83 per cent. The incidence in this study was about ½ of 1 per cent (0.51 per cent), or 39 cases in 7,647 operations. All transperitoneal abdominal operations were considered except inguinal hernias.

Eviscerations occurred anywhere from the first to the nineteenth day postoperatively, the greater number occurring from the eighth to the eleventh day, and the average on the tenth, postoperative day.

The mortality averages about 35 per cent, according to the works of Hartzell[16] and Jenkins.[23] In this series of thirty-nine eviscerations there were 9 deaths, or a mortality rate of 23 per cent. Since it is well known that the complications associated with evisceration are the main causes of death, the slightly lower mortality in this series of cases is probably due to recent therapeutic aids such as sulfonamide drugs and penicillin.

Eviscerations occurred in all age groups from almost newborn to 77 years. The peak occurred in the fifth decade, with an average age of 48 years (table 1). This distribution of cases agrees with other series. Most of the eviscerations are seen in the fifth, sixth, and seventh decades because most of the abdominal operations are performed on patients within this age group. Furthermore, debilitating disease is seen much oftener in this age group.

TABLE 1.—*Age As A Factor*

Decade	Number of Cases
0– 9	2
10–19	1
20–29	3
30–39	3
40–49	11
50–59	10
60–69	6
70–79	3

Sex as a factor in evisceration is relatively unimportant, males and females being affected equally; 20 (51.3 per cent) were males and 19 (48.7 per cent) were females. Little is mentioned in the literature about the relationship of sex to evisceration.[12, 16, 23]

While the relationship of seasons to evisceration is debated in the literature,[16, 14] there seems to be a definite decline in the summer months in temperate climates. The graph on the following page demonstrates this.

Hypoproteinemia [11, 13, 33, 35, 36, 38, 42, 43] avitaminosis,[15, 51] abnormalities of fluid balance[6, 45] and anemia[19, 46] are all important factors contributing to evisceration. Of these four factors, hypoproteinemia is by far the most important. In only 17 of the 39 cases were protein determinations made. Total protein values ranged from 4.66 to 6.87 Gm. per hundred cubic centimeters, with an average of 5.64 Gm. Of the 17, 11 had levels below 6.0 Gm. All proteins were determined by the falling drop method, and the lowest normal for that method is 6.00 Gm.

Of all the vitamins, vitamin C is the only one whose role in evisceration has been proved.[2, 4, 9, 15, 17]

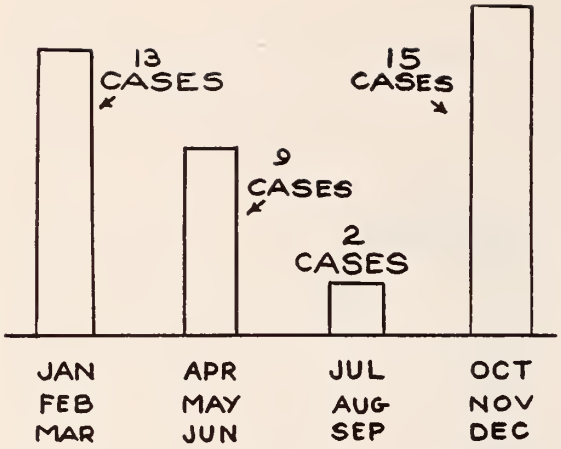

Chart 1

[21, 22, 30, 32, 50, 51] Patients with scurvy definitely are predisposed to evisceration. The study did little to support or disprove the above. Vitamin C determinations were not done, and vitamin C usually was not administered before evisceration occurred. The other vitamins play only a small and indirect role in the pathogenesis of evisceration.

Abnormalities in fluid balance, namely, hypohydration and hyperhydration, impair wound healing.[6, 45] Of those in whom evisceration occurred, 21 patients (54 per cent) showed evidences of hypohydration, while 1 patient (2.5 per cent) had peripheral edema. As criteria for determining hypohydration we used the following: physical examination, inadequate fluid intake, and inadequate urinary output.

Anemia (below 4,500,000 erythrocytes in males and 4,000,000 erythrocytes in females) was present in 23 cases (59.0 per cent) and not seen in 16 cases (41.0 per cent). Inasmuch as it is doubtful that mild anemia impairs wound healing, it is probably the associated hypoproteinemia due to chronic disease which predisposes anemia patients to evisceration.

Any condition which produces increased intra-abdominal tension may contribute to or precipitate an evisceration.[29] Common among the causes of increased abdominal tension are cough, distention, vomiting, and singultus. Their frequency of occurrence is noted in table 2.

TABLE 2.—*Causes of Increased Intra-Abdominal Tension*

	Number of Cases	Percentage
Cough	18	46
Distention	14	36
Vomiting	11	28
Singultus	3	8

Cough was the most frequent cause of increased intra-abdominal tension (46 per cent), and only those coughs which required active specific treatment were considered. Vomiting was considered in cases in which it persisted after the first postoperative day. All cases of distention and singultus were included if their severity warranted mention in the progress notes.

Wound infection definitely predisposes evisceration.[11, 16, 23, 40, 47] Nine eviscerations (23 per cent) were preceded by wound infections. This was especially true with eviscerations through the McBurney type incision for appendectomy (5 cases).

Patients suffering from debilitating disease are much more likely to have evisceration occur.[44] This series of cases supports this idea (table 3).

TABLE 3.—*Debilitating Disease Accompanying Evisceration*

	Number of Cases	Percentage
Weight loss (from history)	12	31
Cancer	8	21
Biliary disease	7	18
Peptic ulcer	4	10
Diabetes mellitus	3	8
Tuberculosis	1	3
Syphilis	0	0

Sutures, the type and location of incisions, and the type of operation performed all play a minor role in the production of evisceration. All cases in which evisceration occurred were primarily closed with catgut, and through and through tension sutures were not employed. No wound closed with interrupted non-absorbable suture material eviscerated. No eviscerated wound closed secondarily with through and through nonabsorable suture material re-eviscerated. Certain incisions in certain regions are predisposed to evisceration.[5, 39, 46] It is interesting to note that 15 per cent of disrupted wounds were through transverse incisions.

Analysis of the cases adds nothing new to the causes of wound evisceration. Rather the study confirms and re-emphasizes many well known principles. No one factor is responsible for wound evisceration. It is the summation of several factors, most important of which is hypoproteinemia. More than half those patients who had protein determinations had hypoproteinemia. The role of hypoproteinemia in poor wound healing has been repeatedly discussed and proved.[2, 3, 4] Surgeons must determine the serum proteins more often, especially on those patients having diseases which predispose evisceration (see table 3). Hypoproteinemia can be effectively combated. When tolerated, a high protein diet is preferred. As much as 300 Gm. of protein per day may be necessary. This must be adequately covered with carbohydrate to prevent the use of proteins to meet immediate caloric demands of the body rather than to restore depleted protein stores. With a diet containing 300 Gm. of protein, the caloric intake must be raised to 4,000 calories.[3] Orally administered amino acids mixed in juices and other palatable media are useful in supplementing the diet. Glucose and lactose may be mixed with amio acids given orally to insure adequate caloric intake. If ingestion of foods is impossible, intravenously administered

amino acids are of some value.[7] Multiple whole blood and plasma transfusions are the most important method of rapidly establishing normal protein balance. As much 2,000 cc. of whole blood or plasma daily may be necessary to restore or maintain proteins.[5, 6]

Water and salt balance must be maintained as described or water-logged tissues do not heal properly.[2] Urinary output and urine chloride determinations are simple, useful guides in controlling fluid balance. Urinary output should be maintained at 1,200 to 1,500 cc. daily, and urine chlorides must be present in adquate amounts. Patients requiring intestinal intubation and those who have fistulae need very careful surveillance. Observations on the role of vitamin C deficiency in this study of evisceration are inconclusive. Others have shown that vitamin C deficiency retards wound healing and lessens the tensile strength of wounds.[8, 9, 10] Lund and Crandon recommend 1 to 4 Gm. vitamin C daily to treat and prevent scurvy in surgical patients.

Postoperative complications greatly increase the probability of evisceration. Cough, hiccough, abdominal distention, and vomiting place increased tension on the suture line. These complications frequently accompany evisceration (See table 2). Distention, vomiting, and hiccough are best treated with intestinal intubation and continuous suction. However, one should be sure to maintain fluid balance. For cough, cough mixtures and opiates are valuable if used knowing their dangers and their role in the production of atelectasis.

J. W. Kennedy[24] and several others[37, 48] state that wound evisceration can be prevented by using through and through sutures in the closure of abdominal wounds. It is the suture of choice in the closure of eviscerated wounds. In this series there was not a single recurrence when this method of closure was used. In those patients suffering from malnutrition, hypoproteinemia, and other diseases which predispose to evisceration (table 3), it would seem feasible to make the primary closure with through and through sutures, thus preventing evisceration. This principle is almost universally applied in the closure of wounds in infants who have had the Ramstedt–Fredet operation for pyloric stenosis. Why not expand this principle to other abdominal operations? The only evisceration following the Ramstedt–Fredet operation was in a patient in whom the wound was closed in layers with catgut.

Wound infection is responsible for a high percentage of eviscerations, especially in McBurney incisions. Wound infection is better prevented than treated. Rigid asepsis in the operating room should include proper masking of personnel and very careful handling of tissues, especially the appendiceal stump. If wound infection is established, wet dressings, antibiotics, and adequate drainage are essential.

Conclusions

Evisceration of wounds is attended by a high mortality. In recent years it has been reduced because of improvements in preoperative and postoperative care. Certain diseases, disease states (especially hypoproteinemia), and postoperative complications predispose a wound to eviscerate. The best treatment for evisceration is prevention. Prevention is accomplished by (1) treatment of hypoproteinemia; (2) maintenance of water and salt balance; (3) prophylactic administration of vitamins, especially C and B complex; (4) treatment of complications early and effectively; (5) primary closure of wounds predisposed to evisceration with through and through nonabsorbable sutures; and (6) rigid asepsis.

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UNIVERSITY OF PITTSBURGH TO PRESENT GRADUATE COURSE IN ANESTHESIOLOGY

A postgraduate symposium on the basic sciences related to anesthesiology will be presented by the department of anesthesiology of the University of Pittsburgh School of Medicine, June 19–23. The departments of anesthesiology of the St. Francis, Allegheny General, and Mercy hospitals will cooperate in the presentation. The course is limited to 30 participants; a registration fee of $25 will be charged.

Details may be obtained from the Chairmen of the Committee on Graduate Medical Education, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Experiences With Rh Hapten*

By JOSEPH W. GOLDSMITH, M. D., F. A. C. S.
St. Paul, Minn.

J. W. GOLDSMITH

Doctor Goldsmith, who is a clinical instructor in the department of obstetrics and gynecology of the University of Minnesota Medical School, received his medical degree from the Long Island College of Medicine in 1938 and following internship, completed a residency at Kings County Hospital, Brooklyn. A diplomate of the American Board of Obstetrics and Gynecology, the doctor served for three years in the Army Air Force before entering private practice in St. Paul in 1946.

MANY antigens may be split into a protein fraction and a specific nonprotein, nonantigenic fraction. The latter part, designated as a "hapten" by Landsteiner,[1] frequently can inactivate or neutralize antibodies developed against the complete antigen. Haptens have been known and used for many years, but it was not until 1947 that an Rh "hapten" sufficiently pure to be used for human beings was isolated by Carter.[2]

Since congenital hemolytic disease of the newborn (erythroblastosis fetalis) is a pathologic state in an infant due to maternal antibodies crossing the placental barrier and attacking the fetal tissues (Levine, 1941[3]), it was thought that such damage might be prevented by inactivating these antibodies with Rh hapten. Studies were begun in 1948 to test this theoretic premise and the results are detailed below.

Materials and Methods

Originally, Carter's method[4] for the preparation of Rh hapten was rigidly followed. From time to time, however, various modifications have been tried and adopted. The present procedure as followed in our laboratories is:

1. Six hundred cubic centimeters of pooled, Rh-positive red blood cells are laked with 300 cc. of cool, distilled water. Outdated bank blood of all Landsteiner blood groups is used after removal of as much of the plasma as possible.
2. The mixture is thoroughly agitated and then refrigerated at 4 C. for thirty minutes.
3. At the end of this time, 4,500 cc. of 95 per cent ethyl alcohol are added. This produces a voluminous precipitate. The mixture is stirred vigorously for one-half hour and refrigerated overnight.
4. The following day, the precipitate is removed by suction filtration with a large (10 inch) Buchner filter-funnel and the filtrate discarded.
5. The precipitate is resuspended in 4,500 cc. of 50 per cent ethyl alcohol. thoroughly mixed for one-half hour, and returned to the refrigerator until the next day.
6. Once again, the precipitate is removed by filtration and is then suspended in 4,500 cc. of 25 per cent ethyl alcohol, mixed thirty minutes, and refrigerated. The 50 per cent alcohol is discarded.
7. On the following day, the 25 per cent alcohol is removed and discarded. The precipitate is suspended in 4,500 cc. of ethyl ether, U.S.P., mixed thirty minutes, and again returned to the refrigerator.
8. During each of the succeeding four days, the mixture is thoroughly stirred for at least one half hour daily and in the intervals is kept at 4 C.
9. At the end of the five day period in ether, the precipitate is removed and discarded. The ether filtrate is retained for further work.
10. The filtrate is evaporated to dryness in a sterile room under ultraviolet irradiation. This is accomplished by pouring small quantities into a Petri dish while a current of air is carried across the surface from an electric fan. The dry residue is light yellow or light amber in color and has a waxy, gummy, or resinous consistency.
11. The residue is dissolved in about 50 cc. of warm 95 per cent ethyl alcohol. A small amount of gray-white, insoluble material is left in the Petri dish, but this contains little, if any, active material.
12. The alcoholic solution is placed in a previously weighed small Petri dish and again evaporated to dryness with the current of air from the electric fan.
13. The final residue is weighed and then dissolved in warm 95 per cent ethyl alcohol to make a concentration of 200 mg. of residue per cubic centimeter of alcohol.
14. This final solution is sealed into sterile 1 cc. ampules.

It has been found that rapid treatment of the protein precipitate with the dilute alcohols (50 and 25 per cent) does not completely remove substances which interfere with the activity of the final product. By keeping the precipitate in contact with each of these alcohols for at least twelve hours, a more active hapten is obtained. It was also found that increased yields could be obtained by more thorough agitation of the precipitate in the ether. For this purpose, a high speed electric stirrer with a large propeller blade has been used.

Although Carter[4] recommended that anesthesia grade ether be used, U.S.P. ethyl ether has been found to be equally satisfactory and is much less expensive. Oxidation products or a large volume of nonvolatile residue, as found in ethers which have been standing or have been exposed to air, will also interfere with the activity of the final extract. As has been previously described,[6] a further modification has been the addition of ultraviolet irradiation during all stages of evaporation to eliminate any possible virus contamination.

To insure sterility, aerobic and anaerobic cultures are made from each lot. In our hands, these have all proved sterile. Activity and standardization are

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

best determined by complement fixation technics similar to that used by Kolmer[6] for the serodiagnosis of syphilis, as has been described elsewhere.[7]

When produced by this method, most lots of Rh hapten will fix complement in a dilution of 1:2,000, and some are active in dilutions of 1:4,000 or greater. Of more than one hundred separate lots, only eight have failed to show activity at dilutions of 1:2,000 and three of these have been active at a dilution of 1:1,000. Empirically, therefore, it was decided to adopt as standard, hapten which gave 4 plus complement fixation with anti-D standard serum at a dilution of 1:2,000 or, in accordance with Carter's[4] definition, contained 2,000 units per cubic centimeter.

To eliminate adverse effects from injection of so much alcohol, each cubic centimeter of hapten solution is diluted with 9 cc. of sterile normal saline solution just prior to administration. A milky white or yellow-white emulsion results. The entire 10 cc. is injected slowly, intramuscularly, deep into the buttocks.

The effective interval of a single hapten injection appears to be from seven to nine days. The first effect on the titer is usually noted from three to five days after the injection. Where treatment intervals have been extended, a rise in titer has been noted in from eight to ten days. Hence, a maximum interval of one week has been selected. In a few instances in which it seemed advantageous to remove an initial titer rapidly or where there had been poor response to weekly injections, biweekly or even daily treatments have been given.

It is very difficult, if not impossible, to control a clinical experiment in the treatment of erythroblastosis fetalis. Hence, only women who have previously delivered children with congenital hemolytic disease of the newborn have been given hapten injections, for it is this group which is most likely to have other affected infants if left untreated.

Results

To date, 28 women (including 3 previously reported[5]) have been treated throughout pregnancy and have delivered, while 20 others are being treated but have not yet delivered.

Normal, healthy, Rh-positive infants have resulted from 16 of these pregnancies. None of these infants has shown any clinical evidences of erythroblastosis fetalis at any time since birth, and all have developed and progressed normally. In 3 instances, the infants' red blood cells were sensitized, as shown by positive Coomb's tests. Follow-up periods have been as long as eighteen months, and all of these children have been frequently checked by competent pediatricians. The other two babies, on the other hand, showed some of the typical signs of mild congenital hemolytic disease of the newborn, but after hapten treatment have survived and are normal. The other 10 babies were severely affected, and most of them showed evidences of severe brain damage. None of these infants survived more than six hours, despite all efforts to save them. The mothers of 2 of these children were first seen at thirty-one and thirty-two weeks of pregnancy respectively, and were known to have had an antititer for at least five months prior to the time they started treatment. All of the others were started on hapten treatment after sixteen weeks of pregnancy. In these instances, the damage (especially cerebral damage) probably occurred before hapten administration was begun. Once this has happened, the changes are irreversible.

In 2 instances, titers of 896 and 448 (blocking anti-D antibodies) have been eliminated within two weeks by injection of 2,000 units of hapten twice a week. In both of the women, this was accomplished before the tenth week of pregnancy. In similar cases, in which the patients were seen for the first time later in pregnancy, it has taken much longer and required more hapten to accomplish the same result.

When produced from pooled red cells of all Rh types as mentioned above, the final product is a mixture of haptens against all Rh antibodies. This has been demonstrated both in vitro and clinically by the changes of titers of anti-D, anti-C, and anti-E antibodies, alone or in combinations, both of the agglutinating (saline) and blocking (albumin) types. The most difficult to eliminate are the anti-E antibodies. At Notre Dame University, Price[8] has purified the hapten and has successfully separated the various Rh haptens by fractional crystallization. He has established that the Rh hapten is an unsaturated fatty acid.

"Toxic" effects have been virtually absent. When present they have been inconstant both in the same patient and in several women given hapten from the same lot. Most have complained of local soreness at the injection site without redness or swelling for two or three days after administration. During the injection, many women have complained of stinging or smarting sensations, but these can be markedly decreased by giving the saline suspension slowly. There have been no systemic reactions directly attributable to the medication either in human beings or in animals. Several women have received as many as thirty or more injections and many others between twenty-five and thirty without apparent untoward symptoms. Some have been given 200 mg. a week and 1 patient has received 400 mg. of hapten each week.

In this group of 50 women who have been or are being treated, three separate types of reactions have been noted. First, the titer may be completely eliminated rapidly. Second, there may be no change of titer whatsoever. Third, the titer may fall and at other times rise with a variety of reactions between falls and rises.

A typical, successful case will serve to illustrate the whole group.

Report of a Case

Mrs. J. F. is a 41 year old white housewife who had been pregnant five times before I first saw her. Her first pregnancy, in 1936, ended with a spontaneous, two and one-half months abortion complicated by profuse hemorrhage. Her husband, whose blood belongs to group O, was used as a donor and she was given 500 cc. of his blood. Her type is group A. She recovered satisfactorily and again became pregnant in 1940. This pregnancy resulted in a full term erythroblastotic stillbirth. The baby was markedly edematous and quite jaundiced when born. Her next pregnancy occurred in 1941, and the outcome was exactly the same. The fourth pregnancy, in 1942, was terminated two weeks prior to term by Cesarean section, and a living definitely edematous, jaundiced, erythroblastotic infant was born alive but failed to survive more than three hours. The following year a second Cesarean section was performed at approximately thirty weeks of pregnancy, in an attempt to avert the previous disasters. This baby, although not severely affected, lived three days only to die of severe erythroblastosis with kernicterus. Completely discouraged by these failures, she visited four or five eminent obstetricians in Minneapolis and each one advised against further pregnancies. Not satisfied with this opinion she journied to the Mayo Clinic and, after complete study, was again told not to become pregnant. Unfortunately, despite all efforts to follow this advice, she became pregnant in August 1948, and when she was approximately two weeks past the expected date of her period she visited Dr. M. T. Mitchell of Minneapolis. He confirmed the diagnosis of early pregnancy and suggested to her that she contact me for hapten treatment. Complete blood studies of both husband and wife at this time revealed that Mrs. F. belonged to group A and was Rh negative. Mr. F. belonged to group O and was Rh positive (Rh_1 homozygous). Mrs. F.'s serum contained Rh blocking antibodies in a titer of 1:4 and 1:8 on two separate occasions during the first week of observation. Treatment with Rh hapten was begun immediately, and she was given 100 mg. of hapten in 9 cc. of saline intramuscularly every week. After these initial titers, she at no time showed any Rh antibodies in her serum. Pregnancy was entirely normal in every other respect except for a moderate weight gain. Fetal movements appeared at approximately four and one-half months, and the fetus was more active than any of the previous fetuses had ever been. At approximately thirty-seven or thirty-eight weeks of gestation, her membranes spontaneously ruptured early one morning and, because of her two previous sections, a third Cesarean section and tubal ligation were performed. A living 6 pound, 2 ounce, normal male infant was delivered. The child cried lustily and spontaneously. No liver or spleen was palpable. There was no apparent edema or jaundice. The amniotic fluid was clear and colorless and the placenta was normal in all respects, both microscopically and macroscopically, as confirmed later. The placenta weighed 510 Gm. The baby's blood was found to belong to group O and was Rh positive. The Coomb's test was negative. The hemoglobin at birth was 17.5 Gm., the red blood cell count was 5,240,000 and there were four nucleated red cells present per 100 white cells in the smear of the peripheral blood. Throughout ten days of observation in the hospital, the baby's hemoglobin never fell below 16 Gm. nor the red cell count below 5,000,000 despite the fact that no further therapy was given to the baby other than that usually given to any newborn. At no time was the liver or spleen felt, nor was there ever any jaundice or edema apparent. He was placed on a routine formula and after initial weight drop, began to gain and has continued to do well. No neurologic signs or symptoms have ever been found in this baby. At present, he is almost 6 months old and has continued to gain and develop normally just as any other baby of this age. He has been checked at frequent and repeated intervals by competent pediatricians and there have never at any time developed any of the signs or symptoms even remotely suggestive of erythroblastosis fetalis.

Discussion

In our experience, Rh hapten has proved useful to prevent erythroblastosis fetalis in some women sensitized to the Rh factor. This has been noted particularly when treatment is begun within the first trimester of pregnancy. Our failures have been in women who have started treatment after the first twelve weeks. Obviously, Rh hapten is not a panacea for the Rh problem, nor can it be hoped that this material will alter cellular damage that has occurred prior to the onset of treatment.

Ideally, treatment should be started before pregnancy to eliminate any residual titer. Once the blood stream is cleared of antibodies and pregnancy initiated, therapy is resumed after the first menstrual period is missed. Under any circumstances, the earlier in pregnancy that hapten administration is started, the more likely are good results to ensue. Carter has now restricted her group to women in the first trimester of pregnancy and to sensitized women who are contemplating pregnancy. Prognosis is often difficult to ascertain, since there is no way of determining the period of gestation at which damage occurs. It has generally been accepted that the absence of antibodies bespeaks a favorable outcome. Hapten can eliminate the antibodies but may not change the fetal outcome if given too late in pregnancy.

Although not available commercially at the present time, gradual increase in private production facilities in this country and in Canada should provide enough clinical material for proper evaluation in the near future. Final critical evaluation and more rigid indications for the use of hapten must await the results of several hundred cases. Carter[9] has observed similar results to the above in those cases in which she has supplied the material for treatment. She claims that she has had no failures in women started on hapten before the first trimester has ended. We have noted one failure in this type of patient.

A great deal still remains to be done to determine the nature of the reaction between the hapten and the antibodies as well as the site of such reactions. Nor has it yet been completely settled whether or not hapten will traverse the intact placenta. It probably does not, since we have eliminated maternal

antititers but have found titers as high as 1,024 in the fetal circulation. These and other similar basic problems are under investigation at present. Synthesis of hapten is being studied but has not yet been accomplished.

Summary

1. A modified procedure for the production of Rh hapten is presented.

2. Discussion of the results of treatment with hapten in 26 women is given. In 16, normal, healthy, Rh-positive infants were delivered, while in the other 10 the children were erythroblastotic.

3. A case report of a typical, successful result with this treatment is included.

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WISCONSIN HEART ASSOCIATION TO MEET IN MADISON

The annual meeting of the Wisconsin Heart Association will be held at the State of Wisconsin General Hospital, Madison, on June 10. The annual dinner will be held at the Park Hotel, with Dr. George E. Fahr, professor of medicine at the University of Minnesota Medical School, the featured speaker. The doctor is also chief of the University Hospital heart clinic.

The day's program is as follows:

9:00– 9:30: Registration

9:30– 9:55: "Friedreich's Ataxia in Five Siblings, all with Similar Cardiac Involvement"—Thomas Lorenz, M. D., Madison

10:00–10:25: "Experience in the Surgical Treatment of Patent Ductus and Coarctation of the Aorta"—Joseph W. Gale, M. D., Madison

10:30–10:55: "Cardiovascular Aspects of Local Anesthetic Toxicity"—John Steinhaus, M. D., Madison

11:00–11:25: "Subenon in the Treatment of Chorea"—J. L. Sims, M. D., Madison

11:30–11:55: "Radioactive Iodine in the Treatment of Goiter"—E. C. Albright, M. D., Madison

12:00–12:25: "Rheumatic Fever Treated with Cortisone"—E. S. Gordon, M. D., Madison

12:45– 1:30: Luncheon, Wisconsin General Hospital

2:00– 5:00: Clinical pathological conference with presentation of four interesting, unusual and instructive cases by

John K. Curtis, M. D., Madison
Francis Rosenbaum, M. D., Milwaukee
Francis Gehin, M. D., Stevens Point
George Fahr, M. D., Minneapolis

A social hour will begin at the Park Hotel at 5:30 p. m., and dinner will be served at 6:30. Doctors' wives are also invited to the dinner and evening meeting, at which Doctor Fahr will discuss "High Blood Pressure." At that time awards will also be presented to the campaign chairmen in the state communities for their service in the recent drive for funds.

Anticoagulant Therapy*

By OVID O. MEYER, M. D.
Madison

O. O. MEYER

Doctor Meyer, professor of medicine and chairman of the department of medicine at the University of Wisconsin Medical School, received his degree in medicine from the Columbia University College of Physicians and Surgeons in 1926. Recently he left on a tour of duty in Europe as an overseas medical consultant of the Army.

AT PRESENT in this country there are two popular anticoagulants available for clinical use, heparin and dicumarol (3,3′-methylenebis [4-hydroxycoumarin]). In Switzerland and Czechoslovakia, another coumarin compound with trade names of Tromexan[1] and Pelentan[2] has been used, and the workers there think that this has certain advantages over dicumarol. Experience with both heparin and dicumarol has now been world wide and extensive since their isolation and synthesis in 1936 and 1940 respectively. Each has advantages and disadvantages and on occasion they are complementary.

Heparin is quick acting and the effect quickly subsides, thus affording good control of the coagulability of blood. It is, however, expensive and must be given parenterally. Determination of the clotting time of venous blood is required for control of dosage.

Dicumarol, like heparin, is essentially non-toxic save for the possibility of producing hemorrhage. It is given orally but the effect is not demonstrable for about twenty-four hours, is not maximal for seventy-two to ninety-six hours, and is ordinarily persistent for an additional forty-eight to ninety-six hours. This synthetic chemical is cheap, and control of dosage is dependent upon the level of the plasma prothrombin rather than the whole blood coagulation time. This is technically more difficult, but as accurate a laboratory procedure as the coagulation time determination.

I wish to elaborate a bit upon the proper method of calculating the prothrombin percentage, for there has been confusion in some quarters. The method we have used has been that of Quick, although we have used the approximate optimal calcium concentration as suggested by Pohle and Stewart,[3] which is but a minor modification. The time required for a fibrin clot to form in the plasma by the method we use is about twelve seconds. This will vary with the type of thromboplastin used and may be as high as fifteen or sixteen seconds. Regardless of this control level, this is taken as 100, or, empirically 100 per cent. There has frequently been the false assumption that, if twelve seconds' time represents 100 per cent, then twenty-four seconds represents 50 per cent prothrombin, thirty-six seconds 33 per cent, etc. This is quite erroneous and has often led to a false sense of security. Quick[4] has shown, and it has been repeatedly confirmed that the coagulation time in seconds of the plasma does not change very much between 100 and 50 per cent prothrombin but does change more rapidly beyond this point. This is shown in chart 1, the curve of human prothrombin taken from the book, "The Hemorrhagic Diseases" by Quick and used through the kindness of Doctor Quick and the publishers. Each laboratory employing this method of doing prothrombin time determinations must set up its own similar dilution curves, and this can be done with little difficulty, using normal saline. With this curve as a guide, one can readily report the correct percentage of prothrombin as well as the so-called prothrombin time.

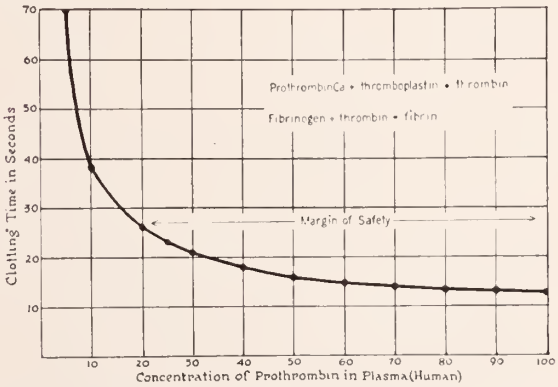

Chart 1.—Human prothrombin curve. The relation of the coagulation time of recalcified plasma (with excess of thromboplastin) to the concentration of prothrombin (from Quick, A. J.: The Hemorrhagic Diseases and the Physiology of Hemostasis. Courtesy of Charles C. Thomas, Publisher, Springfield, Illinois).

Heparin is quantitated in units. Although a unit is not exactly defined, it is usually stated as the amount of the anticoagulant which inhibits the clotting of 1 cc. of blood in the cold for twenty-four hours. Best[5] has suggested that the activity contained in 1/100 mg. of the purest material would be a useful unit. Not all products on the market are of the same concentration, but some are so prepared

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

that 1 cc. is the equivalent of 10 mg. or 1,000 Toronto units of heparin; thus a 10 cc. vial contains 10,000 units. In the average case, it is customary to put 20 cc. in the initial liter of glucose or saline, allow the fluid to flow slowly, and measure the coagulation time at two to four hour intervals until the proper coagulation time is reached, i.e., fifteen to twenty minutes, using the two-tube method of Lee and White for determining the coagulation time, and measuring the time in a water bath at 37 to 38 C. After this is attained, the flow is adjusted to maintain this level; 10 cc. in each subsequent liter is usually adequate, allowing a slightly more rapid flow of fluid perhaps to maintain a proper coagulation time. Two to four hours after the administration of heparin is stopped, the coagulation time of the blood returns to normal. Heparin may also be given intermittently in 50 mg. doses intravenously every four hours, or intramuscularly in Pitkin's menstruum which permits slow absorption of the heparin every eight to twelve hours. This last method of administration has the disadvantage of frequently being very painful. With intermittent injections the prolongation of coagulation time is obviously very irregular, being greatly prolonged at one time and possibly not prolonged at all just before the next injection.

Dicumarol (3,3′-methylenebis [4-hydroxycoumarin]) is the material synthesized by Link and his associates[6] which is biologically identical with the material isolated from spoiled sweet clover responsible for hemorrhagic disease in cattle. It not only reduces the prothrombin in the blood and produces hypocoagulability of the blood in man and in many animals, but, as we have found, also lessens the adhesiveness of platelets[7]. It does not function as an anticoagulant in vitro. Dicumarol usually produces no demonstrable effect upon the prothrombin time until twenty-four hours after its administration. The effect is protracted, reaching a maximum in three to four days and then subsiding for two to four days until return to normal. This prolonged effect, it is obvious, may be either advantageous or disadvantageous, according to circumstances. The usual initial dose is 5 mg. per kilogram. Thereafter we usually give 1.5 mg. per kilogram per day, the dosage being determined by the prothrombin time; when it is too great, the drug is omitted for one or more days until the prothrombin time starts to decrease; then the 1.5 mg. per kilogram dosage as needed is resumed. It is obvious that it requires some experience and skill to judge when the drug should be continued and when omitted. We aim to maintain the prothrombin time at approximately 20 to 40 per cent of normal, a range of seventeen to twenty-three seconds by the method of determining prothrombin time which we employ, where the control time is about twelve seconds for a prothrombin time of 100 per cent. With the above dosage, 80 per cent of patients will obtain desirable prothrombin levels. Some require larger doses, and an occasional patient is very sensitive to the drug. Consequently, individualization of therapy and daily prothrombin time determinations, at least for the first week, and at frequent intervals thereafter, are absolutely essential if accidents are to be avoided.

The antidotes, if excessive hypoprothrombinemia or bleeding result, are transfusions of 500 cc. of fresh blood, perhaps daily for several days and/or the intravenous administration of large doses of synthetic vitamin K, 40 to 64 mg. Ordinary clinical doses of vitamin K are totally ineffectual. It has recently been stated that vitamin K_1 oxide is more effective than synthetic vitamin K.[8]

The indications for anticoagulant therapy are shown in table 1.

TABLE 1.—*Indications for Anticoagulant Therapy*

Prophylactically
After
1. Vascular surgery.
2. Pelvic operations.
3. Splenectomy.
4. Any major operation where there is a history of previous thrombosis, with or without embolism.

Actively
1. Thrombophlebitis or phlebothrombosis.
2. Coronary thrombosis.
3. Unquestioned cerebral thrombosis.
4. Mesenteric thrombosis, retinal thrombosis etc.

Prophylactic therapy has its clearest indication where operation is done upon patients who give a history of previous thrombosis, for the incidence of recurrence is very high. In these cases, as in all cases in which dicumarol is given postoperatively to prevent a thrombotic complication, the therapy is started on the second postoperative day. Thrombosis is not likely before the fifth day and the dicumarol effect will ordinarily be adequate by that time.

Thrombophlebitis and phlebothrombosis are very common. The latter, which is especially dangerous from the standpoint of subsequent pulmonary embolism, often occurs without pain and is not infrequently overlooked. Many modes of treating these conditions have been suggested in recent years. Ligation of the femoral vein, or iliac vein as advised by Homans,[9] (some surgeons have advocated bilateral ligation), is perhaps the surest method of preventing pulmonary embolus and infarction. It is not always a simple surgical procedure and, in the opinion of some, is rather drastic. The need for it increases with advancing years, since the incidence of serious and fatal embolus increases with each decade beyond 40.[10] Ochsner and DeBakey[11] have advised regional sympathetic ganglion block, previously advocated by Leriche, to relieve the arterial and venous spasm and pain. This procedure is not a major factor in preventing embolism.

It is immediately obvious that anticoagulant therapy will not resolve a thrombus already formed whether it is associated with inflammation of the vein or not. If phlebitis exists, the thrombus is usually adherent to the vein and unlikely to travel. The purpose then of anticoagulant therapy is to prevent the development of a second thrombus elsewhere, or a propagated thrombus, a fresh thrombus

at the site of the original one, a thrombus which is likely to be loosely attached and readily broken off to form an embolus. This is the logic of anticoagulant therapy in these cases. Since dicumarol does not exert its effect for twenty-four to forty-eight hours, ideal therapy is the early institution of heparin therapy with concomitant exhibition of dicumarol. Ordinarily when the prothrombin time is prolonged, one may assume that the dicumarol is exerting its effect and that the heparin may be dispensed with.

The contraindications to anticoagulant therapy are shown in table 2.

TABLE 2.—*Contraindications to Dicumarol Therapy*

Absolute

1. Hemorrhagic diseases.
2. Significant liver disease.
3. Moderate to severe renal disease.
4. Subacute bacterial endocarditis

Relative

1. Dietary deficiency states—vitamin K.
2. Fever.

These contraindications require little explanation, I believe. Dicumarol, which usually has a cumulative effect, will have an excessive effect in the presence of severe renal disease. Hemorrhage and the presence of mycotic aneurysms which may rupture are common to subacute bacterial endocarditis; hence the contraindication here; furthermore, anticoagulants are of no value in the treatment of subacute bacterial endocarditis anyway. The deficiency of vitamin K with the resultant hypoprothrombinemia makes caution in the use of dicumarol obviously necessary, and patients with fever have hypersusceptibility to dicumarol.

The results of this type of therapy in the hands of capable physicians are best exemplified in the large series of clinical cases at the Mayo Clinic, recorded in the paper of Barker[12] and shown in tables 3 and 4 through the courtesy of Dr. Nelson Barker. Our results in a much smaller series of cases tend to confirm Barker's observation that subsequent thrombophlebitis and pulmonary embolism are not likely to occur after anticoagulant therapy has been properly administered.

TABLE 3.—*Nonfatal Postoperative Pulmonary Embolism and Infarction*

	Control Group; Anticoagulants Not Administered,		Dicumarol Administered,	
	Number	Per cent	Number	Per cent
Total cases	678	100	292	100
Subsequent venous thrombosis, pulmonary embolism or infarction	297	43.8	3	1.0
Subsequent fatal pulmonary embolism	124	18.3	1*	0.3

*After prothrombin had returned to normal.

The use of dicumarol in the treatment of coronary disease has as objectives the prevention of extension of the original thrombus, the development of a second thrombus or, more important the prevention of a mural intra-auricular thrombus with subsequent pulmonary or cerebral embolus which might well be fatal. The reports of Nichol and Page,[13] Peters Guyther, and Brambel,[14] Wright,[15] Allen, et al.,[16] and Wright[17] covering approximately a thousand controlled cases indicate that anticogulant therapy has reduced the complications and mortality by 30 to 50 per cent. If necessary, as with repeated thrombotic and embolic episodes, dicumarol might be given for years without apparent toxic effects.

TABLE 4.—*Postoperative Thrombophlebitis*

	Control Group; Anticoagulants Not Administered,		Dicumarol Administered,	
	Number	Per cent	Number	Per cent
Total cases	897	100	280	100
Subsequent venous thrombosis, pulmonary embolism or infarction	227	25.3	8*	2.8
Subsequent fatal pulmonary embolism	51	5.7	0	0

*One case of minor pulmonary infarction and seven cases of thrombophlebitis in three of which the value for prothrombin was greater than 30 per cent when the recurrence developed.

In conclusion, then, one can say with considerable assurance that the available tools, especially the anticoagulants heparin and dicumarol, have considerably improved the outlook for the patient with thrombosis or incipient thrombosis. The use of both heparin and dicumarol involves no special hazards except that gross hemorrhage may occur from overdosage or, in the unusually susceptible individual, from the usual dosage. Finally, I would emphasize the need for employment of the anticoagulants when they are indicated and only when they are indicated, careful individualization of therapy and close daily attention to the patient while under therapy.

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UNIVERSITY OF WISCONSIN TO PRESENT SYMPOSIUM ON CANCER

The University of Wisconsin Medical School has announced that a postgraduate symposium on malignant diseases will be held in the auditorium of the Service Memorial Institutes Building on June 20–22.

This symposium has been planned so as to include a discussion of the various types of malignancies in the gastrointestinal tract, the genitourinary tract, and the female reproductive system. The discussion will emphasize differential diagnostic points between the malignant diseases in these areas and those other conditions that may frequently simulate malignancy. The subject will be covered from the standpoint of the various diagnostic technics, such as radiology, gastroscopy, and proctoscopy. Included also will be a discussion of the technic and limitations of the Papanicolaou cytologic diagnostic method.

The faculty will include distinguished speakers from outside of the state as well as members of the departments of surgery, internal medicine, gynecology, and urology at the University of Wisconsin Medical School.

Registration may be made in advance by writing Robert C. Parkin, M. D., 418 North Randall Avenue, Madison 6, Wisconsin. Tuition fees for the course are $25 and checks should be made payable to the University of Wisconsin. For those wishing to register at the beginning of the course, registration will be at 8:00 a. m. on June 20 in the auditorium of the Service Memorial Institutes Building. Classes will continue from 8:30 a. m. on June 20 to noon on June 22. All inquiries for further information should be addressed to Doctor Parkin.

Causes of Persistence of Symptoms Following Operation on the Biliary Tract*

By CHARLES B. PUESTOW, M. D.
Chicago

C. B. PUESTOW

Doctor Puestow, a graduate of the University of Pennsylvania School of Medicine, is a clinical professor of surgery at the University of Illinois College of Medicine. He is also chief of the surgical service at the Veterans Administration Hospital, Hines, Illinois.

SURGICAL treatment of biliary tract disease often is avoided or delayed because of a fear held by many physicians as well as laymen that biliary distress and the need for rigid dietary management will persist after operation. This opinion is based upon the frequent occurrence of postcholecystectomy symptoms. However, when adequate surgical procedures are performed for biliary tract disease which is producing symptoms and in cases in which the organic damage is not too extensive, excellent clinical results usually follow.

The causes of continued distress after surgical treatment of the biliary tract can be listed under three headings, namely: (1) errors in diagnosis, (2) errors in surgical technic, and (3) residual disease.

Errors in Diagnosis

A good history is essential to the diagnosis of biliary tract disease. Pain is one of the most important symptoms. When typical and repeated biliary colics have occurred with radiation of pain around the costal margins or to the right scapula and when qualitative food distress is associated, the diagnosis usually is obvious. If pain is absent or minimal, except in the presence of obstructive jaundice, the diagnosis of biliary tract disease should not be made without very careful study.

Cholecystography is a great aid to the diagnosis of gallbladder disease. It is highly accurate in establishing the functional capacity of the gallbladder and often in visualizing calculi. However, a diseased gallbladder does not always produce symptoms and may not be the cause of a patient's complaints. To remove the gallbladder for symptoms due to other causes will not cure the patient. Routine autopsy studies show a high incidence of cholecystitis and cholelithiasis in individuals who at no time gave a history of biliary distress. Roentgenographic findings of a nonfunctioning gallbladder are not sufficient justification for cholecystectomy if the history does not support the diagnosis. Contrarily, a normally functioning gallbladder by x-ray does not always exclude cholelithiasis. When the history of biliary colics is typical and examination supports the diagnosis, cholecystectomy may be indicated even though a normal cholecystogram has been obtained. Without x-ray confirmation, however, the surgeon should be thoroughly convinced of the diagnosis before operating upon the biliary tract.

A number of other diseases produce symptoms suggestive of biliary tract disease. Cholecystectomy under these circumstances may be followed by persistence of symptoms. Functional dyspepsia is one of the most common conditions confused with biliary tract disease. Patients suffering with functional disorders may complain of qualitative food distress, indigestion, belching after meals, and epigastric discomfort. Their symptoms can be differentiated from gallbladder disease by the absence of severe pain and tenderness, the indefiniteness of their symptoms, and their nervous temperament. This group of patients constitutes the greatest number of cholecystectomized patients with persistence of symptoms postoperatively. So-called spastic colitis is a common functional disease and often is accompanied with constipation or diarrhea and flatulence, belching, and indigestion. Cholecystic disease may be coexistent, but, if it is not producing typical gallbladder symptoms, cholecystectomy is unlikely to relieve that patient's symptoms.

Pancreatic disease can produce symptoms suggestive of biliary tract abnormalities. Pancreatic pain can be as severe as biliary colic. Its location is usually deep in the epigastrium, with radiation through to the back. It may be the result of acute or subacute inflammation or pancreatic calculi. Fortunately, acute inflammations both of the gallbladder and of the pancreas respond best to conservative treatment. Thus sufficient time can be allowed for studies to help make a differential diagnosis.

Peptic ulcers produce characteristic symptoms which, when present, make the diagnosis fairly apparent. Acute perforation or subacute penetration of an ulcer may closely simulate biliary disease. If a perforation occurs, evidence of peritonitis is more apparent and air under the diaphragms shown radiographically aids in making the diagnosis.

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

Diaphragmatic hernias, especially of the hiatus type, with a portion of the stomach located above the diaphragm, may be responsible for a chronic type of indigestion characterized by distress and belching soon after eating, which may simulate biliary disease. Patients with such conditions seldom have severe pain. The true nature of their disease can be determined by fluoroscopic studies of the esophagus and stomach. A hiatus hernia and cholelithiasis may coexist. When this occurs, the removal of the gallbladder seldom will be followed by relief of symptoms.

Coronary artery disease may produce pain simulating biliary colic. A differential diagnosis often is difficult. This is especially true when both diseases are present. If the attack is of cardiac origin, epigastric or right upper quadrant pain and tenderness may be present but usually are less severe than in biliary colic. Other evidences of heart disease may be noted and electrocardiographic evidence can be obtained.

The most important factor in avoiding surgical procedures on the biliary tract for symptoms produced by other diseases is a carefully taken and evaluated history. Laboratory and x-ray aids are of value in supporting a clinical diagnosis but should not be used as a substitute for careful clinical study and judgment.

Errors in Surgical Technic

It is my belief that biliary distress and indigestion are due largely to the tonus of the sphincter of Oddi associated with a nonfunctioning gallbladder. This deprives the upper intestinal tract of adequate bile in the early stages of digestion. Relief of symptoms is due to removal of disease and to a loss of tonus of the sphincter of Oddi, which accompanies a complete cholecystectomy. This release of tonus is apparently on a neurogenic basis and is dependent upon adequate surgical treatment. The following conditions may result in irritation and intermittent spasm of the sphincter, producing symptoms: incomplete gallbladder removal with or without stones; a long cystic duct stump with or without stones; stones in the common bile duct; or diseases of adjacent organs which may irritate the extrahepatic biliary tract. These include duodenal ulcer, chronic pancreatitis, regurgitation of bile into the pancreatic ducts, and disease of the lymph glands adjacent to the choledochus.

The foregoing causes usually are the result of inadequate surgical treatment. Damage to the extrahepatic biliary and arterial system may result in postoperative symptoms. If the hepatic artery or a main branch is ligated or damaged and the patient survives, damage to the liver may be serious. The common duct or hepatic ducts may be damaged by instruments or partial or complete ligation, the resulting symptoms usually being proportionate to the damage done. Gauze packing in the gallbladder bed may press against or damage the ducts or vessels. It is most important that all surgeons performing operations upon the biliary tract have a thorough knowledge of the anatomy and anomalies of these structures. Damage to them can be avoided if a careful dissection of them is made at the time of operation and no structure is clamped or divided until it is thoroughly identified.

Residual Disease

If disease of the biliary tract has existed for many years and especially if infection has been associated, there may be considerable damage to the liver as well as to the gallbladder and bile ducts. Removal of the gallbladder cannot be expected to eradicate such disease. If a suppurative cholangitis has existed, complete removal of stones from the duct and subsequent drainage will not clear up the infection in their walls. Long standing or intermittent obstruction to the common duct will produce liver damage which may be reflected in the patient's future health. Such damage can be avoided by early diagnosis and treatment.

Biliary Dyskinesia.—This and similar terms have been used to define the postcholecystectomy syndrome. It has been explained as a physiologic spasm of the sphincter of Oddi. From experimental and clinical evidence, I believe that the sphincter of Oddi rarely, if ever, goes into spasm following cholecystectomy without an organic cause. This may be residual disease in or of the bile ducts or irritation of them by contiguous disease. Careful surgical exploration of patients with postcholecystectomy spasms and pain usually will reveal the etiologic factor, and its correction will relieve the patient's symptoms.

Good results following operation on the biliary tract depend upon correct diagnosis, early treatment, and technically correct surgical treatment. If a surgeon undertakes an operation upon the biliary tract, it is his responsibility to get the patient well. He must be sure of his diagnosis, must know the anatomy of the field, and must, as far as possible, correct existing disease. Postcholecystectomy syndromes should not be considered as a purely physiologic abnormality to be referred to an internist for subsequent care. If disease is present only in the gallbladder and the remaining hepatobiliary system is undamaged, cholecystectomy should give complete relief of symptoms in better than 90 per cent of patients. As the patients are converted physiologically into the type of animal that never possessed a gallbladder, they should be able to live a normal life without dietary or other restrictions directed at the hepatobiliary system.

Artificial Eardrum as an Effective Hearing Aid

By ARTHUR KOVACS, M. D.
Milwaukee

ARTHUR KOVACS

A graduate of the Royal Hungarian University of Budapest, Doctor Kovacs completed a residency in otolaryngology in municipal hospitals in Budapest. Since 1927, he has been practicing in this field in Milwaukee, where he is on the staff of Mount Sinai Hospital.

WHEN, due to long standing suppuration, a patient's hearing is so reduced that it is insufficient for undisturbed contact with his surroundings, an artificial eardrum may restore the audition to near normal level.

The effectiveness of this simple aid is limited to a certain percentage of deafened individuals. While statistical data were never collected, the writer, experimenting with this prosthesis for over thirty years, estimates it to work in 80 per cent of selected cases.

The artificial eardrum is a moistened cotton pellet applied to the exposed promontorium of the middle ear. Its physical properties and mode of action do not imitate that of the eardrum, and it is not lodging in its position.

A patient with one good ear has never been advised to wear an artificial eardrum, although occasionally such a partially disabled individual will benefit.

In a child with materially damaged hearing, normal mental development is greatly retarded. Such a child will avoid his playmates and will be compelled to attend special classes or, if a borderline patient, regular ones under enormous obstacles.

In one instance, the backward stage of a 16 year old youth was observed to undergo a remarkable change from the time of first application of the artificial eardrum. The morose disposition soon yielded to cheerful optimistic outlook, ambition in school work returned, graduation from high school was achieved without difficulty, and work in the family's sphere of interest entered with avidity.

Middle-aged and elderly people long deprived of normal social contact or regular employment welcome the long needed aid with similar gratification.

In a paper by Marcus Banzer, "Disputatio de auditiene lesa," published in 1640, first reference is made to the use of artificial membrane. Yearsley in 1848[1] and Erhard in 1849[2] proposed independently of each other that in cases in which there was a perforation of the eardrum, a ball of cotton should be inserted up to the remnant of the membrane in order to improve the power of hearing. However, only after the publication of Toynbee in 1852, who constructed a special membrane, was the interest of specialists aroused, and the invention is generally connected with his name.

The great value of this device was proposed in the American literature as early as 1889 by H. N. Spencer.[3] Spencer stressed the great usefulness of the method in cases in which, with ordinary ways of treatments, no improvement could be obtained. He cited patients who were again able to enter into undisturbed intercourse with those about them after loss of hearing function for many years.

It is merely of historic interest that Toynbee applied a 6 mm. rubber plate fixed to a silver wire which corresponded to the length of the meatus. Toynbee's artificial drum membrane has been modified by different authors, who all reported their satisfaction and its usefulness. Eschweiler in 1926[4] and Alexander in 1927[5] stated that all these modifications have been more or less given up for the benefit of the cotton pellet. However, A. G. Pohlman[6] has lately devised a new and apparently simple and effective form of hearing device, and V. Nasiell[7] has acquired considerable reputation on the continent with his prostheses cut from cellophane foil. Coates,[8] on the other hand, praises the effectiveness of a piece of glazed paper that fits snugly over the perforation of the drum.

These new modifications have not reached wide application, because of dependence in their use on the physician, which is not the case with the moistened cotton ball. Any mildly antispetic nonirritating solution will serve as a moistening medium. Glycerin and heavy oily solutions are not favored by this writer, on account of frequent necessity of cleaning the tympanal cavity.

The placing of the artificial eardrum on the promontory is a matter of patient experimentation while one addresses the near-deaf individual in a quiet conversational voice until sharp sounds strike the hearing organ. No direction can be formulated as to particulars. However, the size of the cotton ball will differ from case to case. Too large or too small plugs will not work and, above all, the plug should be fluffy and contain a moderate amount of moisture.

The clumsiest patient will learn the application of the drum in a limited time. Lack of success in the first sitting shall not be deterrent. Only repeated failures will compel one to give up further experimentation as apparently useless.

The patients who require this aid have mainly chronic suppurative disease of the middle ear with advanced destruction. There is more or less total destruction of the ear membrane, malleus, and incus; the necrotic, rigid, long shaft or what is left of it being in solid apposition to the medial wall of the tympanum. The pellet may prove an efficient aid in radical mastoid cavity.

Occasionally retracted scars without perforation will benefit, especially if the scar overlaps the niche of the round window.

It is good practice to try the artificial membrane at the patient's first visit to the office. Most of the patients with a purulent ear condition of long standing are skeptical individuals who have been subjects of ear treatment and lack the necessary perseverance for a successful experimentation. However, if they experience an unexpected sudden recurrence of long lost hearing, they change their mental attitude without any persuasion.

Both middle ears should be meticulously cleaned and dried and then the membrane tried. Often, on one side the first touch of the promontory will create excellent hearing while the other will show no response. Inspection of the middle ear will give no clue; test of perception ability of the ear may likewise prove misleading. If the suppuration is active, every endeavor should be practiced to create a perfectly dry cavity; if the middle ear is dry and its mucous membrane pale, thin, shiny, and devoid of inflammatory irritation, its tolerance to a foreign body should be tested by leaving the cotton pellet in the tympanum for a few days.

Should some light moisture appear at the end of three to four days, it will not be a signal of failure. However, heavy purulent secretion will complicate matters. In such instances the drum should be worn for short periods and possibly removed for the night. In case the hearing is enhanced equally well on both sides, the plug should be worn in one ear at a time, giving rest to the other one.

Often an originally overly sensitive mucous membrane after repeated trial will tolerate the irritation for one to two days without secretion. For the patient with sufficient skill at replacement of the prosthesis, this is entirely satisfactory.

In some instances such a membrane and cavity will show a marked scaling, which, when reaching a certain grade, will require rinsing and cleaning of the tympanum.

It has been my experience that usage of alcohol drops in a dry cavity will enhance the general tolerance of same.

The artificial eardrum replaces in function the impaired or destroyed middle ear structures. It fulfills their service in transmitting sound waves. For this purpose the cochlear apparatus must be in fair shape of health and reception of high sounds normal or close to normal. Alexander postulates that reduction of C_4 tuning fork shall be less than ten seconds.

Not infrequently the cotton plug after being worn for some time actually improves the hearing. This was dramatically illustrated in the case of a young woman with poor hearing who became very proficient in adapting the prosthesis. When she returned a year after the fitting of the prosthesis, she had no plug, as she felt no need for it any more. The improvement was astounding.

Lillie and Kranz[9] have noted the same phenomenon, stating that their subject, after having used the prosthesis for over four years, believes that the hearing has gradually improved during this time and that he is not noticeably deaf any more as far as general conversation is concerned.

Barany[10] states that the hearing improvement prevails after the removal of the artificial drum. For explanation of these remarkable results we have to turn to the phenomenon of sound stimulation of the hearing mechanism and its associated sense organs. As early as 1802, Itard,[11] a Parisian otologist, in a treatise expressed the opinion that musical tones serve as agents to restimulate the defective action of the auditory nerve and awaken its functioning possibilities. Sound vibration is the most valuable stimulation for the ear and a reawakening of the auditory sense cannot be accomplished without its application.

At the turn of the last century, Urbantschitsch,[12] a distinguished Viennese otologist, devoted great patience and energy to the acoustic stimulation by progressive speech exercises. This author stated that deficient hearing is not due solely to deficient acoustic stimulation but rather to not using the hearing apparatus, to disregarding its still existing performance ability. In case of advanced pathologic changes, finally, a complete lassitude may develop. By methodic speech exercises, stimulation should be supplied for improvement of the subnormal activity.

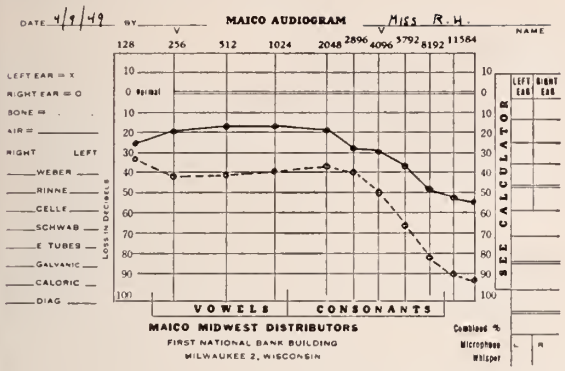
While Urbantschitsch used mainly speech for stimulation, Goldstein,[13] in developing his acoustic method, has used both human voice and sonorous instruments. He states that daily five minute application of an acoustic record to an affected ear will serve to increase residual hearing from 10 to 35 decibels of a definite tone frequency, in selected cases.

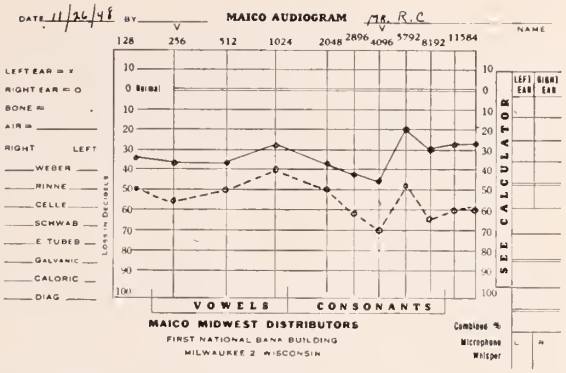
In consideration of these rationalizations the improvement of ear function under the influence of an artificial eardrum should rather be the rule than the exception. However, as far as the writer can recall, auditory stimulation under similar circumstances has never been subject to investigation. Exact proofs by audiograms are not available.

The following two audiograms indicate the hearing differences with and without artificial eardrum on the date when it was taken.

The audiogram of R. H. is a true expression of the performance of the artificial drum. For appreciation, it should be noted that a normal conversation in an adjoining room, not addressed to her, was overheard.

The audiogram of R. C. was taken after wearing the pellet for over ten years, in which the auditory stimulation may have elevated the unaided hearing to a considerably higher level.





The interrupted line indicates hearing without aid.

The audiogram without the plug may have shown at the time of the first application a lower curve and, therefore, a greater difference.

There is no clear agreement as to action of the artificial ear drum. It is generally accepted that sound can reach the internal ear through both the round and the oval windows. Under normal conditions, the transmission occurs through the chain of ossicles and oval window.

When the ossicular chain is destroyed, vibrations impinge on both windows, therefore neutralizing their effect on the endolymph in opposite directions. In case one of the windows is closed to sounds, vibrations will permeate without handicap through the other window. Interestingly, Barany,[14, 15] giving this explanation to his experiments on the artificial eardrum, postulated a restored hearing in case of fixation of stapes, once another labyrinth window is made. This prophecy reached perfection in the Lempert fenestration. Accordingly the moistened cotton covering the round window opens the pathways for sound vibrations through the other fenestra, and hearing will be restored. When the mercury drops in Barany's experiment covered the round window, the hearing was enhanced, while on the oval window the hearing immediately disappeared.

Barany's experiments were confirmed by Hughson[15] and Crowe, who too, found in their experiments that when the round window membrane was made rigid, the perception of spoken words and practically all tones was increased by at least 50 per cent. Histopathologic observations of Stacy R. Guild[16] also tend to corroborate the role of the round window and explain the function of the artificial ear drum as round window fixation.

The interpretation of action as a sound conductor or amplifier as contended by others (Pohlman[17, 18]) could hardly explain the effectiveness of the moist cotton merely on one side with equal or even further advanced cochlear involvement.

In the single conclusion drawn from these observations, that no patient should be deprived of the benefit of the artificial eardrum if that is the sole way of restoring his hearing, I trust, otologists will concur wholeheartedly.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Intravenous Administration of Procaine in Children

David Schrum[1] (Houston) employed intravenous administration of procaine in 5 children with serum sickness or a related allergic disorder and in 1 child with a severe burn of 60 to 70 per cent of the body surface. Relief in these patients, whose conditions were otherwise uncontrollable, was gratifying. Out of this experience the following arbitrary dosage schedule and procedure for administration of procaine intravenously to children was devised:

Skin test with 0.1 per cent procaine hydrochloride.

Appropriate dosage of phenobarbital twenty minutes before starting intravenous administration of procaine.

Procaine hydrochloride, dissolved in either physiologic saline or 5 per cent glucose in water, to give a 0.1 per cent solution.

Dosage:

2 to 5 years—125–250 cc.
5 to 10 years—250–500 cc.
10 to 15 years—500–750 cc.

Intravenous administration by slow drip: 20 to 30 drops per minute during at least two hours. Repeat in eight hours if necessary.

Have on hand sodium amytal for intravenous use in case of excessive central nervous system stimulation.

Early toxic symptoms observed in these cases were numbness, nausea, and dizziness, which were considered symptoms requiring decrease in rate of administration. In event of restlessness and irritability, the drip should be discontinued and sodium phenobarbital given intramuscularly. Convulsions and respiratory failure would be probably adequately antidoted by intravenous administration of sodium amytal, but these symptoms do not seem to occur when procaine is given by slow intravenous drip. In adults, the drip has occasionally been followed by chills, with or without flushing, and low grade fever one to twelve hours after treatment. The drug is also sometimes amazingly diuretic.

Procaine probably should not be given to patients who (*a*) are hypersensitive by skin tests; (*b*) have extensive liver damage; (*c*) suffer from myasthenia gravis; (*d*) have epilepsy or family history of epilepsy; (*e*) have a history of recent head injury. It is probably not contraindicated in patients receiving sulfonamides and certainly not in those who are taking penicillin.

Following a few hours' intravenous drip of procaine, pain has sometimes been abolished in adults for many hours or even days, but we do not understand precisely how this effect is brought about. Possibly there is some direct action on cells, or the effect is mediated through the antihistaminic and antiacetylcholine actions of procaine, or maybe the higher centers are directly or indirectly affected. The extreme rapidity with which procaine disappears from the plasma, and the relative persistence and high concentration of diethylamino ethanol, one of its breakdown products, suggests that the latter might account for some of the pharmacologic properties of the parent drug.—HARRY BECKMAN, M.D.

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INTERNATIONAL ACADEMY OF PROCTOLOGY TO HOLD CONVENTION

The Second Annual Convention of the International Academy of Proctology will be held at the Bellevue Hotel, San Francisco, June 23, 24.

The session will consist of scientific papers and the annual banquet will take place on Friday evening, June 23.

Further information concerning the convention and a copy of the program may be obtained by writing to the Secretary, Dr. Alfred J. Cantor, International Academy of Proctology, 43–55 Kissena Boulevard, Flushing, New York.

THE MEDICAL FORUM

RURAL HEALTH CONFERENCE SET FOR SEPTEMBER

National Guard Needs Help for Inoculations

Critical Shortage of Medical Assistance

Madison, May 11.—County medical societies and reserve medical corps officers are being urged by the Interim Committee of the State Medical Society to give all possible assistance to the National Guard in relieving its pressing need for physicians to make physical examinations and inoculations of National Guard members going to summer training camp in mid-July.

Current strength of the Wisconsin National Guard is 8,250 men all of whom are required to spend two weeks at summer camp. Prior to this training period the entire personnel should be inoculated for typhoid, paratyphoid and tetanus.

The problem is aggravated by the fact that Guard medical officers who might normally do the job are located in only five of the 75 communities in which the men

(Continued on page 401)

Nearly 60 Organizations Invited to Co-Sponsor Meeting in Wausau

Madison, April 25.—Plans for a state-wide rural health conference under the joint sponsorship of nearly 60 organizations are being advanced by the State Medical Society's committee on rural health under the direction of Dr. M. W. Stuessy, Brodhead.

The conference is tentatively scheduled for mid-September at Wausau.

The decision to hold the conference was made at a meeting attended by Dr. Stuessy, Dr. C. N. Neupert, state health officer; Oswald Anderson, Wisconsin Farm Bureau; Kenneth Hones, Farmers Union; Jack Kyle, Wisconsin Association of Cooperatives; Edith Bangham, University of Wisconsin home economics extension, and Wakelin McNeel, state 4-H club leader.

Enthusiastic support was given the proposal for a conference aimed at finding new avenues for the improvement of health in rural areas of the state and carrying an "action program" to the grass roots.

Detailed plans will be laid at a meeting on May 25 with representatives of all organizations interested in acting as co-sponsors of the rural health conference. Nearly 60 organizations have been invited. Others may participate merely by indicating an interest in rural health problems.

Returns from questionnaires mailed to interested groups and agencies indicate a lively interest in such topics for the conference as how to get more doctors into rural areas; improving hospital facilities; prepaid medical care plans; high cost of medical care; need for better personal hygiene and sanitation; need for more preventive medicine and health education; problems of the aged, and the need for health councils and full-time health departments.

New Committee Urges Expanded Effort in School Health Field

Madison, May 11.—The newly organized school health committee of the State Medical Society held its first meeting in Milwaukee to review the health education programs being conducted by the State Board of Health and the State Department of Public Instruction.

The committee is under the direction of Dr. F. J. Mellencamp, Milwaukee.

Health examinations of school children and follow-up care of the deviations revealed in the youngsters occupied the committee's attention. Dr. W. R. Manz, Eau Claire, reported that mass examination of children in "assembly line" fashion is being superseded by individual examination in doctors' offices.

The school board of which he is chairman believes, he said, that the individual examination is a more effective health education device and gives the school a better appraisal of the child's health.

The committee in cooperation with the Bureau of Maternal and Child Welfare of the State Board of Health is planning to publish leaflets for parents on school readiness and school health examinations. It has also requested more

F. J. MELLENCAMP

emphasis on school health subjects in the Society's 26-station radio broadcast, the "March of Medicine."

Other members of the new committee are Drs. E. B. Pfefferkorn, Oshkosh; Amy Louise Hunter, Madison; and E. C. Edwards, Racine; Miss Catherine Campbell, health educator with the State Board of Health; Orlo Miller, health educator with the Department of Public Instruction, and Miss Janet Jennings, director of the Division of Public Health Nursing, State Board of Health.

WAKE-UP GENTLE PEOPLE

By Dr. T. D. Elbe
Thiensville

(Reprinted from Mequon Town Talks, Thiensville, February, 1950.)

A situation that has been with us for fifteen years and which has been so complex that only now is the realization of its many effects dawning upon us. One can well ask why we have not recognized prior to this time the cause and effect of this intricate and complicated law which is espoused by the bureaucrats and socialists as a long step forward.

The warnings that the country is going Socialist are late. This bill in itself is the entry of our nation into Socialism. How can I say such? Let's follow some of the early history of the Social Security Act.

Beginnings

Bismarck, the father of Socialism, in the 1880's in looking about for new sources of income proposed a dual scheme: on the one hand the Government was to take over control of banking, communications, and insurance; on the other hand it was to set up compulsory State insurance to provide extremely small cash benefits and free medical care for the very poorest part of the population. Bismarck's advisor stated that these compulsory laws were designed not only to **raise revenues** and **redistribute** wealth, but also to control the personal expenditures of the working class through regulative channels. Since the state could thus regulate, the term "social insurance" to describe the above was coined. This, folks, is where our social insurance laws also gather its name. How can this last be said?

Other ministers of finance grabbed at this easy means of revenue and in 1911 both Great Britain and Russia adopted compulsory health insurance and other parts of Bismarck's plan. In 1919 the International Labor Organization was formed as a part of the League of Nations neither of which America joined. The International Labor Organization adopted Bismarck's plan as its own during the next fifteen years. In 1934 through the influence of Frances Perkins and by approval of Franklin Roosevelt the United States of America became a member. In so doing we agreed to have our social legislation comply with the Socialist principles set down at Geneva. Roosevelt immediately appointed the Committee for Economic Security. Two men were brought over from Geneva to help draft the Social Security Act. The law as passed in 1935 was something wholly foreign in concept and philosophy to America. Probably few

T. D. ELBE

people at the time and even fifteen years later, save the planners, realized or realize the Socialist structure of the Social Security Act. I ask you is there reason for my saying that we now have socialism to an extent?

Have Promises Come True?

What were the promises at the time that Altmeyer in 1935 presented this bill to Congress. We were to be rid of destitution. Are we? I believe not. We were to have better labor management relations. Have we? For an example as to this falsity our strike time lost in 1949 has only been exceeded by that terrible year of 1937. We were to wipe out the feeling of insecurity among the aged but I believe one can rightfully say that our aged are laboring under the greatest feeling of insecurity ever known. A few have fallen heir to lush benefits but many more have been completely ignored and neglected.

I believe that an American's impression is that he should get that for which he pays but do we under this law? The Supreme Court itself has said that it is perfectly all right for the government to collect taxes from you for nine years eleven months and twenty-nine days and there is no obligation for any return. You believe this can't be and isn't being done? Try and collect benefits at age sixty-five if you have not paid in for ten years and get the answer. What about the woman who works prior to marriage and pays into the fund for eight or nine years. What is her equity after marriage? That is right, it is exactly zero.

Workers are not buying insurance, they are not paying premiums, they are paying an ordinary income tax. Few people understand that in order to collect on Social Security one may not be earning more than $14.99 per month. That is month not week. The bureaucrats are trying to increase this monthly earning limit but that still does not deny that you are not buying the insurance you have so long thought you were.

How Payments Are Used

This money which is being paid into Social Security is not being set aside as one would think in a true fund as is required of insurance companies but is being used for the day to day government costs. How does this take place? The premiums (rather taxes) are used to purchase bonds from the Treasury department which are truly only a promissory note on which 2% interest must be paid. This interest money is then transposed on the books to the Social Security Department only to be sent back for more bonds. Where does this interest money come from? It comes from the Treasury department who collects the taxes.

Therefore what is happening? The people are being taxed to pay the interest on money that has already been given to the government as taxes. Sounds silly doesn't it? Yet it is true. How much does this interest amount to which comes from all the taxpayers and not only those that are covered under Social Security. The figures are as follows: 1940—$42,000,000 — 1945—$124,000,000 — 1949 (fiscal year) $230,000,000. This is a ten year total of $1,200,000,000 stolen from the American taxpayer.

I could go on for a longer desertation but I feel sure that the above should prove to you that the Social Security Act as it now stands and which is trying to be enlarged is one of the greatest gyps of all times.

Do not feel that I am not in favor of Social Security although I feel too much stress is being placed on those that have had their opportunities while none is being placed on the young of our nation on whom we must depend. The congress of today is taxing any little child within your knowledge for our government's operation today which is too much for us to pay.

Canada has a law in which each child receives a benefit until age eightoen. This in my opinion is a much better security law than the one that exists in our books.

I maintain your representatives in Congress should know your feelings regarding this sprouting and growing plant of Socialism.

AMA ASKS DISCIPLINE FOR EXCESSIVE FEE CHARGERS

Chicago, Feb. 25.—The Board of Trustees of the American Medical Association recently urged the formation of grievance committees by county and state medical societies and added that it looks with "disfavor on the few members of the Association who charge excessive fees." The full statement of the Board of Trustees follows:

"The House of Delegates at its Washington, D. C., meeting in December, 1949 adopted a resolution which proposes the establishment of grievance committees by county and state medical societies. When this resolution was presented to the House, attention was drawn to the success of the committees already established in some states.

"The Board of Trustees believes that the medical profession will be pleased to learn that at least eighteen medical societies now have grievance committees. These committees hear grievances concerning alleged improper practices or injustices. Frequently fees are involved.

"The Principles of Medical Ethics state in part: 'A physician is expected to uphold the dignity and honor of his vocation.' Unfortunately, there have been reports of physicians' taking advantage of patients by charging exorbitant fees. Such reports, even though isolated, create an unfavorable impression of the entire medical profession. The establishment of grievance committees permits fair hearings for patients and physicians wherever the patient has been unable to adjust the matter satisfactorily with his physician. Sometimes a complaint is due to misunderstanding, perhaps because the physician neglected to explain to his patient the nature and cost of the services rendered. Such an explanation is especially indicated if unusual expenses are involved.

"The Board of Trustees of the American Medical Association looks with disfavor on the few members of the Association who charge excessive fees. It urges state and county societies to discipline those members who, after a fair hearing and a decision that the fees charged have been excessive, refuse to reduce their fees to a level that is reasonable for the services rendered."

Barron County Health Council Joins State Group

Barron, Wis., Mar. 22.—An enthusiastic group of Barron County citizens met recently to vote to affiliate the Barron County Health Council with the Wisconsin Public Health Council.

Twenty members of the County Council met to review the health needs of the area and outline a public health program for the county.

Miss Inez Halsted, county supervisory teacher, was elected secretary to replace Mrs. Bernice Grant who recently resigned. The Health Survey Committee reported that 28 out of 35 governmental units in the county had responded to a campaign to determine the amount now being spent on public health in Barron County.

Sen. Hunt Warns Dentists Against Socialized Medicine

Milwaukee, April 11.—The American Dental Association and the American Medical Association must give the people an answer to the problem of health insurance before 1952 or "it will be bad for everybody," warned Senator Lester C. Hunt, (D. Wyo.) in a speech at the Wisconsin State Dental Convention in Milwaukee.

L. C. HUNT

Among the physicians present at the meeting were Drs. J. W. Truitt, R. E. Fitzgerald, J. C. Sargent, N. J. Wegmann, E. A. W. Habeck and Richard Foregger.

Sen. Hunt is the only dentist in the U. S. Senate, and the author of S. 4290, an "alternative" bill to S. 1679, the administration's compulsory sickness insurance measure.

Sen. Hunt's bill provides a federal Department of Health with cabinet status and a National Health Insurance Board which would provide a "voluntary" health insurance policy, at a premium to be set by the Board, for those who wished to buy it.

He told his dental society audience that his bill would "in no way socialize the professions," but he added that he had "no objection to Congress subsidizing it if necessary for low income people."

"While we must make it clear that we'll have no truck with socialized medicine," Sen. Hunt added that the ADA and the AMA "must devise some method of handling the health insurance problem," and it "must be solved before 1952 or it will be bad for everybody."

He pointed to the remarkable health record of America achieved under the present system of health care, and said that his personal observations in Britain indicate that "dentistry is deteriorating" under socialized medicine.

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ROVING AMBULANCES SAVE LIVES IN DANE COUNTY

Squad Cars With Stretchers Win Race Against Death

The hired man on the Joe Bilka farm was feeding corn stalks into the shredder last fall. In half an hour the gang would quit for supper. Suddenly his leather glove caught on a bundle and before he could say "McCormick Deering" his hand and half his arm had been chewed up by the slashing knives of the shredder.

For a second the gang was panic stricken. It was 14 miles to the nearest hospital—9 miles to the doctor.

Someone remembered the telephone.

Within 15 minutes the hired man had been relieved from his pain—the bleeding was stopped, his wounds were being sutured, his shock was under control.

This incident occurred in Dane County, Wisconsin. Similar accidents happen every day in every county of the state. But, up to now, only in Dane county do accident victims get "another chance" as the result of organized methods of rushing emergency cases to medical attention by a round-the-clock ambulance service using special police squad cars.

This extra chance is the Dane County Traffic Department under the direction of Russell W. Klitzman. Its five squad cars outfitted as ambulances keep a constant vigil along Dane county's main highways and lesser side roads.

Accident victim being placed in ambulance.

When Joe Bilka's hired man got his arm in the shredder a Traffic Department station wagon was only three miles from the farm. The telephone call to the sheriff's department was relayed by radio to the cruising car and aid was on its way within a matter of seconds.

Director Klitzman says this system is "paying off." Although the accident rate is higher than ever before, more lives are being saved. The combined squad car-ambulance technique started in 1947.

In 1948 Dane county had 680 traffic deaths. The following year there were 736 accidents, only 23 deaths. Already this year traffic accidents are 25% higher than in 1949, but there have been only 8 deaths.

The Traffic Department doesn't confine its services to auto accidents alone. Klitzman's roving squad cars have had many a race with the stork. Some careless hunters owe their lives and limbs to his alert defense against accidental death. Farmers all over the county look to his department as a kind of "accident insurance."

The Dane County Traffic Department started the ambulance feature in its squad cars in 1935, but it made many improvements before it evolved the present station wagon equipped with regulation stretchers.

Today, each of the five squad cars has seats for the driver and another officer and is equipped with a two-way radio, two rolling stretchers and a complete and extensive first aid kit. Experience has shown the need for a simple oxygen unit, now under consideration.

The squad cars are a station wagon model from the low-priced field, but they are capable of speeds up to 95 miles per hour, according to Klitzman. "The ability of our drivers and their knowledge of local roads gives us a tremendous advantage over anyone who tries to outdistance us," he says.

(Continued in next column)

Director Klitzman with squad car.

Dr. Bell is Special Delegate to AMA Meet

Madison, May 1.—Dr. John M. Bell, Peshtigo, has been appointed to serve as State Chairman for Wisconsin at the National Conference of County Medical Society Officers at the American Medical Association's annual meeting in San Francisco, starting June 25.

J. M. BELL

Doctor Bell will represent the State Medical Society of Wisconsin in a discussion of problems of county medical societies in the economic and public health field.

"Time is the all important element," says Director Klitzman. "And we often save lives because we have the equipment to win the race against time."

"Among the seriously sick and injured we are asked to transport, we save at least two persons for every one who dies," said Klitzman.

Already the effectiveness of the Dane county plan is becoming known around the state. Several southern Wisconsin counties have inspected the system and contemplate setting up similar services in conjunction with their police departments.

"The squad car-ambulance idea has many possibilities," Klitzman contends, "and I should think that its life saving features alone would cause any county to give serious consideration to its adaptation in some form."

He pointed out that counties without their own radio transmitter might investigate the possibility of using the radio network of the Wisconsin State Traffic Patrol.

PROBLEM OF AGED AT ACUTE STAGE, DOCTORS TELL LEGISLATIVE COUNCIL

Madison, May 9.—There is no escape from the problem of caring for Wisconsin's ever increasing aged population and further dealy will only complicate its solution, the Legislative Council has been told.

In a special hearing on the care and treatment of the aged and chronically ill, the Legislative Council heard physicians, judges and public welfare officials plead for some kind of action to eliminate the necessity for committing the aged to insane asylums for care.

Nearly 10 per cent of the population is over 65 years of age and persons in this category are increasing at the rate of about 60,000 every 10 years, the Council was informed. Nearly 9,000 of these need immediate infirmary care.

In a statement read to the Legislative Council because of his absence, Dr. H. H. Christofferson, Colby, chairman of the State Medical Society's committee on mental hygiene, urged the building of separate county infirmaries.

"I contend that we have as much need today for the segregation of the old people from the insane people as we had 75 or 80 years ago when we separated the insane from those in jails and poor houses," Dr. Christofferson declared.

Dr. Christofferson concluded that "even a modest start on a solution to the problem will cost money," but urged the Legislative Council to "meet the situation with honesty and take the problem to the people."

Dr. P. R. Minahan, Green Bay, past president of the society and member of the mental hygiene committee, warned that postponing action will only make the problem more costly and difficult of solution.

Pierce County Judge J. H. Grimm, Ellsworth, and Dane County Judge George Kroncke, Jr., Madison, said they have no choice but to commit the aged and senile to mental institutions to spend their last years. Both urged an immediate solution.

The new director of the state department of public welfare, John Tramburg, said that the legislature's first step ought to be to determine standards of care in the various types of institutions and then "stick to them."

A. J. Thelen, Madison, representing the Wisconsin County Boards Association, admitted the urgency of the problem, but called all proposals to date "too costly" until federal, state and county laws on the matter are unified.

Senate Over-rides Truman on VA Hospital Cutback

Washington, D. C., May 1.—The Senate Labor and Public Welfare committee has received H.R. 5965, the bill passed by the House which directs Veterans Administration to proceed with construction of 16,000 additional hospital beds at an approximate cost of $240,000,000.

Although the measure was sent to the Senate committee for action immediately after its passage by the House, no forwarding steps were taken pending the Florida primary election on May 2 in deference to Sen. Pepper, chief advocate of hospital expansion.

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Remind Doctors of Procedures for Getting State Aid for Vets

Madison, May 11.—A special communication to all Wisconsin physicians and hospitals has been sent by the Wisconsin Department of Veterans Affairs advising them of the policy and procedures to be followed in making the departments available to World War II veterans.

The letter points out that the Wisconsin legislature declared it the policy of the state to give health, educational and economic assistance to veterans of the armed forces of World War II and their dependents, providing they meet certain specifications.

To be eligible for these benefits, the veteran must have been honorably discharged after 90 days or more of active service between August 27, 1940 and July 25, 1947. Only bona fide residents of the state can apply for benefits.

Assistance is granted only after a complete investigation of each case by the department, and only after there is evidence of want or distress, that no misconduct is involved, and that the assistance will be a contributing factor in the veteran's rehabilitation.

The department makes the following suggestions to physicians:

1. That he keep on hand a supply of DVA Form 45 which should be sent to the county veterans service officer to obtain authorization for treatment or hospitalization.

2. That the physician concerned must establish the patient's status as a veteran.

3. Prior authorization must be obtained except in emergencies before proceeding with treatment.

4. In emergencies the county veterans service officer or the department be notified within 5 days by DVA Form 45 or other available means.

5. Itemized bills should be submitted in duplicate. Payment will not be more than the schedule of fees paid by the Wisconsin Veterans Medical Service Agency.

Pregnancy is not considered as a disability. If the veteran can liquidate his obligations in an orderly manner on a monthly basis, he will not get aid. Congenital or chronic disabilities are considered only on a temporary basis, and children of veterans under 16 years suffering congenital or chronic ailments should be referred to other coordinating state agencies where possible.

BIG BUDGET FOR ACTH RESEARCH

Washington, D. C., May 1.—Grass roots appeals from physicians and the public are one explanation of why a House committee added $2,500,000 to an appropriation for research in cortisone and ACTH.

The House appropriations committee, which usually reduces rather than increases, made the decision to spare no money on this project. It boosted the requested appropriation to a total of $3,600,000.

However, there is almost no possibility that even Congress' generosity will make these preparations any more generally available in the near future. The supply is infinitesimal in relation to demand and costs remain extremely high because the only known production method is complicated and expensive.

CIO Wants Voluntary Plans to Meet Labor Standards

Detroit, April 12.—The UAW-CIO, Social Security Department is proposing a set of 5 standards which must be met by voluntary prepaid medical plans before such plans will be recommended for utilization by organized labor.

The proposed CIO policy statement on voluntary prepaid medical plans reads as follows:

"Pending the establishment of an adequate national health program it is necessary for Labor to utilize various types of voluntary prepaid medical plans, including commercial insurance and medical-society-sponsored Blue Shield plans. Most of these voluntary plans are unsatisfactory because of limited scope of services available, high operating costs, limited or no public or labor representation on policy boards, restrictive protection (because benefits are cash in-

(Continued on page 401)

BLUE CROSS COUNCIL TO HAVE LAY ADVICE

Milwaukee, April 25.—Representatives of business, civic, social, farm, trade, labor and educational segments of the state will help determine future Blue Cross policies through an Advisory Council set up at the annual corporation meeting of Associated Hospital Service, Inc., at Milwaukee on April 25.

The establishment of the Advisory Council was approved unanimously by over sixty corporate members from all over the state. B. E. Miller, Madison, president of the Blue Cross explained that the members believe the Council will be able to assist Blue Cross in formulating policies which will be more responsive to the public needs.

Mr. Miller added that the success of Blue Cross is determined by the degree of friendly and voluntary cooperation it receives not only from hospitals and doctors, but from every segment of the community. Public suport and greater enrollment will come from the community's better understanding of Blue Cross aims and operations, he predicted.

Officers re-elected at this meeting are Miller, president; Dr. Robert F. Purtell, Ralph M. Hoyt, both of Milwaukee, and Sister Mary Fridoline, La Crosse, vice presidents; Joseph C. Moser and the Rev. William G. Sodt, both of Milwaukee, treasurer and secretary, respectively.

Named directors were Sister Mary Bernadette, William L. Coffey, George P. Ettenheim, Dr. E. O. Gertenbach, R. G. Hayssen, Dr. T. J. Howard, M. E. Knisely, John J. Krill, and the Rev. A. H. Schmeuszer, all of Milwaukee; Olive M. Graham, Wausau; Dr. E. P. Hayes, Eau Claire; Hugo Kaems, Sheboygan; Dr. A. J. McCarey, Green Bay; O. B. Maphis, Kenosha; E. L. Smith, Superior and Fred T. Goes, Milwaukee.

Over 750,000 people in Wisconsin already participate in the Blue Cross hospital care plan, with 400,000 of these members enrolled in the doctor-sponsored Blue Shield surgical-medical plan. To make these services readily available to the people, 127 hospitals, representing 99% of all hospital beds in the state, are affiliated with Blue Cross.

DOCTOR'S COMMITTEE GUIDES SUCCESSFUL VET PROGRAM

JOINT PLANNING BY SMS AND STATE BENEFITS DOCTORS AND VETERANS

Madison, May 11.—Back of the success of the Wisconsin veterans medical and hospital care program, through which thousands of ex-G.I.'s have been able to obtain high quality health attention, is an interesting story of close cooperation between the State Medical Society and the State of Wisconsin Department of Veterans Affairs.

The Veterans Medical Service Agency of the State Medical Society has played a key role in helping more than 22,000 Wisconsin veterans obtain medical and hospital care at government expense for their service connected disabilities.

The Wisconsin Department of Veterans Affairs under the direction of Gordon A. Huseby, Madison, has administered a law, passed in 1945, under which nearly 10,000 needy veterans or their families have received state assistance for their hospital and medical care.

G. A. HUSEBY

In such widespread activities by both agencies working in the same field it was inevitable that their policy and administrative problems often would be completely interwoven.

Close relations between the two agencies has meant that Wisconsin veterans received their care from the agency best fitted to serve their needs with the least delay.

The foundation for this joint effort was laid in August, 1943, when medical society and department representatives suggested that a "medical advisory committee be created which could assist in determining policy or making decisions on controversial cases."

B. J. HUGHES

First members of the committee were Drs. B. J. Hughes, Winnebago; R. P. Montgomery, Milwaukee; and A. J. Wiesender, Berlin.

Foreseeing the problems which arose after World War II, Dr. C. A. Dawson, River Falls, then a member of the State Board of Veterans Affairs, recommended that this advisory committee be given official status in the department of veterans affairs.

Members of the Advisory Committee

Dr. B. J. Hughes, Winnebago, Chairman
Dr. S. M. Evans, Milwaukee
Dr. A. J. Wiesender, Berlin
Dr. W. S. Middleton, Madison
Dr. R. W. Blumenthal, Milwaukee
Dr. J. S. Supernaw, Madison
Dr. W. J. Bleckwenn, Madison

It was realized from the start that there was dual advantage in a group which served as an advisory committee to the State Medical Society at the same time that it acted as an official committee of the department. Continuous membership on this committee was felt advisable to maintain continuity of policy and develop a wider view of veterans' problems. Accordingly, the statutes now provide that members of the committee serve as long as they are willing.

This close harmony between two important agencies—one private and one governmental—has been a boon from the administrative standpoint. For the veteran it has meant better health. For the doctor it has meant more efficient service and less red tape.

CIO Sets Insurance Standards

(Continued from page 400)

demnity rather than a guarantee of necessary medical service), prohibitions against group practice, and lack of provision for strengthening quality of medical services.

It is, therefore, the policy of CIO that voluntary prepaid medical plans should meet the following standards as a condition for utilization by organized Labor:

1. Prepaid medical plans should assure that services needed by the worker or his family will be provided in accordance with medical needs and not on a cash indemnity basis. Payments under the plan must be accepted by physicians as full payment for services rendered. This requires acceptance by groups of physicians of fee schedules for full payment of their services which should not be more than the amounts usually paid by such governmental agencies as Veterans Administration.
2. Labor and other consumer groups must be adequately and effectively represented on the policy making boards of prepaid medical care plans.
3. These plans must maintain minimum operating expenses and follow efficient administrative practices.
4. The plans must assure free choice of physicians or of groups of physicians who are associated in prepaid group medical practice.
5. The plans must provide for enforcement of high standards of care and continuous improvement of quality care."

National Guard Asks Help

(Continued from page 395)

live. The assistance of practicing physicians in almost every community therefore becomes a necessity, says Dr. John W. Truitt, president of the Society.

No funds are available to pay hometown practicing physicians for the time spent giving inoculations, although medical reserve officers may claim full drill credit for time spent in such activities.

Each county medical society is asked to immediately contact its local Guard units to determine the situation and offer its assistance in providing these inoculations for local members of the Guard.

"Whattaya expect? They took out for old age retirement, union dues, sick-benefit and hospitalization, group insurance, withholding tax, employes' benefit association, and I bought a newspaper."

From "Best Cartoons of the Year 1949" [Crown].

How the Persians Taught the People Simple Economics

(By Austin Kiplinger—Reprinted from The Chicago Journal of Commerce, March 2, 1950.)

Once upon a time there was a Persian prince who was ordered by his father, the Sultan, to educate his people in economics. The young prince, full of enthusiasm, called in the wise men of the realm, who were known as "economists," and he said: "Oh, wise men of Persia, bend thyselves to this great task, that we shall teach the people economics. I have but one simple commandment—you must tell the whole truth."

The wise men went away to deliberate and write. When a week had passed, they returned with their collective work, which by this time covered the upper and nether sides of a thousand pages. The leader spoke: "Oh prince, we have produced this great text for the people of thy realm. In it you will find the whole truth about economics, including 4,346 footnotes, 78 graphs, 43 appendices, and 27 exhibits." The prince scowled. "Varlets," he cried. (Of course, he used the Persian word.) "This is much too long. The truth is never so complicated as you have put it." And he ordered his guards to behead the senior economists among those who had prepared the report.

The surviving wise men returned to work and after one more week, they again approached the prince. This time they had condensed the work to a pocket-size guide. The leader spoke: "Oh prince, may it please your sultanic grace, we have produced this indispensable handbook of economics, replete with index of subjects, in which the lowliest herdsman can find light on any subject, whether it be 'marginal utility,' 'logarithmic progression,' or 'the law of the adverse minimum.'"

The prince took the book, thumbed through its pages and flushed with rage. "Pashti," he roared, (which is the Persian word for "scum"). "This is not the language by which to teach the people economics. Are there no men among you who have the common touch?" And he ordered all the wise men beheaded except two. To the two remaining economists, he said: "Retire unto your tents and work, each unto himself. At the end of the seventh day, bring me your results."

The men retired, and at the end of the seventh day, they reappeared to face the angry prince. The first wise man stepped forward. "All right," demanded the prince, "let me see your work," and the economist, who was a man of the people, presented a slender volume, filled with big letters and simple words, and printed on only one side of the page, and he said:

"This is the simplest text that can ever be presented to the people. It contains the truth, and nothing less would ever be sufficient." The prince looked pleased, and bethought himself of the prize that he would bestow on this wise man.

Suddenly his thoughts were broken by the strident voice of the second wise man, who said, "Attend, oh prince, to the wisest words of all." The prince looked, but could see no book. "Where," he asked, "is your work? Let me see your scrolls."

"No, my liege," he said (speaking, of course, in Persian), "I demand that you behead this impostor economist, for I have the simplest truth of all."

"Let me see it," demanded the prince.

"I do not need to write it," said the economist, "I can tell you in nine words. Listen, and I will speak the text by which all the people of this great realm shall learn the truth of economics." The prince listened and the man said:

"There is no such thing as a free lunch." (by Austin Kiplinger, Chicago Journal of Commerce, March 2, 1950).

AMA RELEASES FILM DIRECTORY

Chicago, April 15.—Reviews of 225 medical and health films are now available in booklet form from the American Medical Association.

The Committee on Medical Motion Pictures of the AMA has recently revised its booklet entitled "Reviews of Medical Motion Pictures," and a brief description and evaluation of each motion picture is included. Copies are available at a cost of twenty-five cents each from the Order Department of the American Medical Association.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Steatorrhea

Steatorrhea simply refers to an excess of fat in the stool. It is not a disease entity in itself, but it is a manifestation of certain diseases which are not uncommonly a source of much diagnostic and therapeutic confusion.

It is the purpose of this communication to present a classification of steatorrhea and to point to certain observations and laboratory findings which may be helpful to the physician in establishing a differential diagnosis.

Classification

Steatorrhea may be either pancreatic or intestinal in type.

1. Pancreatic steatorrhea. Associated with
   a. Acute and chronic pancreatitis
   b. Pancreatic calculi
   c. Neoplasms
   d. Cysts, including congenital fibrocystic disease of infants
2. Intestinal steatorrhea. Associated with
   a. Tropical sprue
   b. Nontropical sprue
   c. Celiac syndrome
   d. Biliary obstruction
   e. Obstruction of mesenteric lymphatics as by neoplasm, lymphoma, tuberculosis, and trauma
   f. Intestinal lipodystrophy and lipogranuloma
   g. Gastroenteric and gastrocolic fistulae
   h. Regional enteritis
   i. Sequels of protozoan and bacillary dysenteries

Pancreatic versus Intestinal Steatorrhea

1. *Gross Appearance of the Stool.*—A striking increase in bulk and weight of the stool of a patient on an average diet not too high in vegetable matter strongly indicates the presence of steatorrhea.

In pancreatic steatorrhea where the digestion of fat is retarded and an excess of neutral fat is present the stool is generally soft, greasy, or oily, and of a yellowish color. Where the primary defect is a failure of intestinal absorption, there is an excess of fatty acids or soaps. Here the stool may be gray or white, salvelike, and rancid.

In sprue there is frequently a long history of diarrhea with copious, pale, frothy, and offensive stools.

It should be emphasized, however, that the presence of diarrhea or even the finding of a well formed stool of usual color does not rule against the presence of increased fat.

2. *Microscopic Study of the Stool.*—The presence of many undigested meat fibers and the finding of large amounts of neutral fat as refractile globules (Sudan III stain) or minute needles suggests a pancreatic rather than an intestinal type of steatorrhea. Some workers try to improve the accuracy of this admittedly crude observation by the use of a Schmidt diet (118 Gm. of protein, 111 Gm. of fat, and 191 Gm. of carbohydrate. Total of 2,234 calories).

3. *Chemical Examination of the Stool.*—According to Beazell, Schmidt, and Ivy[1], pancreatic dysfunction (pancreatic achylia) is usually associated with the simultaneous failure in the absorption of fat and nitrogen. Quantitative fecal fat and fecal nitrogen determinations are carried out in some hospital laboratories, but many workers consider them time consuming, nasty, and not always dependable.

It has been customary in the establishment of a diagnosis of congenital fibrocystic disease to prove the absence of pancreatic trypsin in aspirated duodenal secretion. The passage of a duodenal tube, however, has serious faults, namely, difficulty in the placement of the tube in a frightened or seriously ill child, trouble in obtaining much secretion, especially in the presence of diarrhea, dehydration or marasmus, and uncertainty in always being sure that only duodenal juice has been obtained. Recently, our attention has been directed to the determination of trypsin by a photographic film technic. Ayers, Stowens, and Ochsner[2] feel that the method has real merit and that fecal assays give findings which correlate well with determinations on duodenal contents.

4. *Amino Acid Tolerance Tests in Pancreatic Deficiency.*—The gelatin tolerance test, developed by West, Wilson, and Eyles,[3] depends upon the oral administration of gelatin and the determination of blood amino acid nitrogen levels. In the presence of pancreatic deficiency (low trypsin content) there is no rise of blood amino nitrogen. It should be pointed out, however, that impaired intestinal amino acid absorption can give an erroneous picture, and this possibility should be checked by the use of an additional test, namely, a glycerine tolerance test[4] which makes use of the simple amino acid, glycine, as the test substance, and then measures the rise in blood amino nitrogen. Glycine, unlike gelatin, requires no tryptic digestion before absorption.

The procedures again eliminate the use of a duodenal tube specimen, but substitutes the difficulty of blood amino acid determinations.

5. *Vitamin A Tolerance Test.*—We can no longer consider the finding of impaired vitamin A absorption as diagnostic of pancreatic achylia. It has been shown repeatedly that poor assimilation of vitamin A is a fairly common occurrence, having been reported in a variety of conditions, including diarrhea, celiac syndrome, and certain allergies.

(Continued on page 426)

Proceedings of the Milwaukee Academy of Medicine March 21, 1950

Clinical Use of Anticoagulants*

By EDGAR V. ALLEN, M. D.
Rochester, Minn.

THE device provided by nature to control hemorrhage is actually harmful in some instances as well as protective. It is doubtless true that hemorrhage causes fewer deaths than intravascular thrombosis. This concept must replace that of old, in which physicians repeatedly wished for simple and effective methods for the control of hemorrhage. It is now known that many may live normally if coagulation of blood is substantially impaired whence thrombosis of blood vessels and its consequences occur less readily. The problem of thrombosis is much greater than that of hemorrhage as evidenced when it is the complication of phlebitis, arteriosclerosis, thromboangiitis obliterans, coronary artery disease, congestive heart failure, and cardiac irregularities. If pulmonary embolism is accepted as being a major cause of death in many conditions of intravascular clotting, then it may be realized that nature has provided too well. Further, these observations emphasize that health of man would be greatly improved if intravascular thrombosis did not occur, especially in the instances as mentioned above. The new era in therapy implies the use of anticoagulants as a major step in the direction of preventing intravascular thrombosis and hence preserving the health and life of man.

Two preparations are available clinically which impair the coagulation of blood and, therefore, may be used to prevent intravascular thrombosis. Heparin is the first drug which is available, but it demands parenteral administration at relatively high cost and has a further disadvantage in the lack of a suitable antidote for overdosage. The other drug, dicumarol, may be given by mouth and is inexpensive, and its effects can be counteracted by large doses of vitamin K and blood transfusions. However, it has disadvantages of considerable import. The administration of dicumarol must be governed by repeated determinations of blood prothrombin levels by a reliable laboratory. In addition, the immediate effect of its administration may be delayed for 24 or 48 hours; whereas, it may continue to be active many hours or days after its administration has been stopped. Overdosage by use of these drugs in great quantity or by the small quantity of the drug in a susceptible individual has a distinct disadvantage of potential hemorrhage that occurs with either of the anticoagulants. It must be emphasized, therefore, that the physician must maintain a firm and steady course of therapy between that of overtreatment (hemorrhage) and insufficient treatment (development or recurrence of thrombosis or embolism which one is trying to avoid). The administration of dicumarol, therefore, must be based on prothrombin values, and administration by any other criteria may lead to the disaster of hemorrhage or inadequate control of coagulation. Furthermore, identical amounts of the drug may produce widely dissimilar effects on the prothrombin when administered to different persons or to the same persons on different occasions. The indispensable factor in dicumarol therapy is availability of experienced and reliable laboratory service which performs prothrombin determinations. We have found the Quick method entirely reliable and satisfactory. We avoid the notation of prothrombin "time" and use the prothrombin "percentages" in the control of therapy. The variability of thromboplastin potency and various modifications of technic preclude the use of prothrombin "time." Irrespective of the prothrombin potency and knowledge that identical prothrombin *times* do not indicate the same prothrombin quantity we have come to use only the percentages. The problem has been further simplified by the observation that critical figures in treatment are those representing 10 per cent, 20 per cent, and 30 per cent of normal prothrombin. One may administer dicumarol adequately knowing only these figures, for experience has indicated that intravascular thrombosis rarely occurs when prothrombin in the blood is less than 30 per cent of normal and that bleeding rarely occurs when prothrombin value is 10 per cent or more of normal. This effective range is generally maintained by administering 300 mg. of dicumarol in the first day of therapy after a prothrombin determination has been done. On the subsequent day, if the value of prothrombin is more than 20 per cent of normal, 200 mg. is given. If less than 20 per cent, none is given. If the value of prothrombin is decreasing rapidly but is more than 20 per cent, no dicumarol is given; however, if the value is rapidly rising but has not yet reached 20 per cent, the drug is given on that day. In the cases in which the prothrombin determinations indicate a patient sensitive to the effects of dicumarol, only 100 mg. may

* The complete paper by Doctor Allen is available from the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3.

be given in subsequent doses instead of 200 mg. On the other hand, if it is found that patient's blood is insensitive to the effects of dicumarol, then 300 mg. may be given instead of 200 mg. Ordinary therapy is continued until the patient has been ambulatory for approximately one week. It should be noted that the effect of dicumarol may continue for a number of days after therapy is stopped. It is doubtful that protection against intravascular thrombosis is afforded when prothrombin value of the blood is above 30 per cent of normal. It is advisable to urge that the dicumarol therapy be in the hands of one or two men in a hospital in order to assure accurate treatment. It is impossible for individual physicians to obtain sufficient experience with the drug by the treatment of a case now and then.

In our experience, 64 mg. of menadione bisulfite injected intravenously corrects excessive prothrombin deficiency, and bleeding is generally stopped. Likewise, a transfusion of 500 cc. of whole blood is also effective. The appearance of excessive prothrombin deficiency produced in a course of dicumarol therapy is a signal to discontinue the therapy temporarily and then possibly to resume treatment with smaller doses. If an emergency operation must be performed, then large amounts of vitamin K and transfusions may be given before operation. In the patients who are receiving heparin, discontinuation of the therapy for two or three hours will permit blood to return to normal state of coagulability and allow satisfactory emergency surgical treatment.

Control of excessive prothrombin efficiency may be adequately accomplished by high doses of vitamin K and fresh blood transfusion. When emergency situations arise such as necessitate for operation, the effects of dicumarol may be removed by vitamin K and transfusions.

INDUSTRIAL GROUP TO MEET IN SAN FRANCISCO

The Western Association of Industrial Physicians and Surgeons invites all American Medical Association members to attend its meeting on June 25 (the day prior to the opening of the A.M.A. convention), from 9:00 a.m. to 5:00 p.m., in the Curran Theater, 455 Geary Street, San Francisco. The program includes: "Tetanus Prophylaxis in Previously Immunized Persons," Rodney R. Beard, M.D.; "Medical Administrative Problems in Workmen's Compensation Cases," a panel; "A Rest Regime for Acute Back Sprain," Christopher Legge, M.D. and Harry W. Walker, M.D.; "Psychosis, a Side Door out of Industry," Frank Tallman, M.D.; and "Job Placement in the Rehabilitation of Alcoholics," a panel.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION OFFERS POSTGRADUATE COURSE

The National Gastroenterological Association announces that a course in postgraduate gastroenterology will be given at the Hotel Statler, New York, on October 12–14.

The course, which will again be under the personal direction of Dr. Owen H. Wangensteen, professor of surgery at the University of Minnesota Medical School, will cover the following subjects: diseases of the mouth, diseases of the esophagus, peptic ulcer, diseases of the stomach, diseases of the pancreas, cholecystic disease, psychosomatic aspects of gastrointestinal disease, diseases of the liver, diseases of the colon and rectum, and other miscellaneous subjects, including pathology and physiology, radiology, and gastroscopy.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, New York.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

E. S. CAMERON

Doctor Cameron, a 1934 graduate of the Johns Hopkins University School of Medicine, joined the Wisconsin State Department of Health in 1940 as maternal and child health physician. In 1941, when the Mental Health Division was established, she became the director. She had worked in pediatrics and psychiatry at the Johns Hopkins Hospital, serving on the staff as clinical psychiatrist and as assistant director of the Children's Psychiatric Clinic until coming to Wisconsin.

Promoting Mental Health

At least 30 per cent of your patients come to you with complaints for which you can find no organic basis. They come complaining of headache, gastric distress, cardiac pain, or easy fatigability, listlessness, loss of appetite. Their symptoms are legion. They simulate every imaginable disease. Yet on physical examination you discover no lesion. And none is discoverable.

These men and women are emotionally disturbed. They are not malingering or pretending. They are suffering. Their pains are real, just as real as the pains caused by a physical difficulty. But the causes are different. The "lesion" lies in the person's total adjustment to life,—to his wife, or his job, or his children, or his conscience. He cannot come to terms with reality as he finds it, and he develops symptoms.

When you begin to study him you find he is reacting to life's stresses and strains. His present problem may have started long ago, perhaps even in childhood. He began even then to develop poor patterns of handling difficult situations. Perhaps he escaped by becoming ill. Other people develop different types of symptom formation. But these methods of attempting to solve problems are not adequate. Such persons grow up emotionally disturbed or neurotic or antisocial, or have personality problems or have psychosomatic illnesses developing.

Because the beginnings of this poor life adjustment lie in early life, it is essential that any preventive program emphasize those early years. That is when preventive measures can best be taken. Parents can be helped to handle their child so his needs, physical and emotional, can be met and he has the opportunity to develop into a healthy person. Parents can be directed to sources and materials and services that will be helpful.

To make this more easily possible, the Wisconsin State Board of Health has established a preventive program which has as its function the spread of mental health education and services especially for early problems. It organizes demonstration community guidance centers where the services of a team of three—a psychiatrist, a psychologist, and a social worker—are made available to a patient referred for diagnosis and treatment, after examination by his own family physician.

Complete study of the many factors contributing to poor adjustment is essential if any real cure is to be expected. Physical status, intellectual capacities, manual skills, interests, achievements, aspirations, as well as the economic, social, neighborhood, school, and community factors must be known. Then, and most important of all, the interpersonal relationships, the emotional reactions, and the internal conflicts must be thoroughly understood.

After such a diagnostic study is completed a treatment plan is recommended. When it is necessary, psychotherapy is carried out by the trained specialists. Environmental and attitudinal therapy involves cooperative work with the persons referring the patient. The clinic staff members hold conferences with referring workers at which cases are discussed. This helps those professional people apply mental hygiene principles in their daily work with other children as well. In addition to this type of in-service training, group discussions and lectures interpreting the needs for normal personality development are regularly conducted in each of the communities served by such a center.

Parent education is a most important phase of prevention. It is in the home that the need for a sense of security can best be met. It is there that adequacy feelings can be developed, and a child can learn to accept social interrelationships happily. A film library has been developed to provide means for a mental health education program for the public at large. Organizations may borrow these visual aids. Each one is accompanied by its own discussion guide. Pamphlet material on subjects of interest to all parents is distributed on request. Radio transcriptions for use by local groups are circulated. All these materials are on the everyday problems of the everyday child.

Every parent has questions and every child has problems. Prevention at this point is most meaningful. If you bring help to them the instant that questions and problems arise, the difficulties need not grow. It is simpler to give help at that level than years later when they come to your office with chronic complaints.—EUGENIA S. CAMERON, *Director, Mental Health Division.*

. . . . THE PRESIDENT'S PAGE . . . .

Go West, Young Man

THIS advice from Horace Greeley would be appropriate for June of 1950. At that time doctors everywhere will watch events at the American Medical Association annual convention in San Francisco. Thousands of physicians will actually make the trek, not necessarily as pioneers in the ordinary sense, but certainly as determined adventurers in relatively unexplored fields of scientific knowledge and uncharted economic spheres. And, no doubt, millions of other Americans will be watching.

The annual convention is an event that should stir the interest of the most complacent physician. To the intern, it is his best introduction to the medical profession. The resident's medical armamentarium is reenforced for his coming venture into actual practice. For every physician, it is an expression of the ethical, honest, alert, humane, scientific art and practice of medicine.

To be intensely practical, however, most interns and residents may find a meeting half way across the continent quite outside their means. But I sincerely hope that the bonds of professional brotherhood will prompt many physicians in Wisconsin to share a seat with some intern or resident in exchange for a turn at the wheel.

San Francisco would be worth a visit even if the convention weren't being held there. It's the change of scenery needed each year just as much as the annual physical. The city will keep the family busy while each physician observes the House of Delegates meetings. The three official Wisconsin delegates to the meeting will certainly be glad to see members from their own state. The general and sectional meetings always have a wealth of knowledge, and the scientific displays are more than worth the time one has for them.

Doctors have many important reasons for being at the 1950 American Medical Association convention. This is the year in which each one should "stand up and be counted" among those who accept the precious personal responsibility of choosing freedom over socialism. Fellow physicians who have spearheaded the fight against compulsory sickness insurance cannot win the battle alone. True, more than 4,000 organizations are now marching with us in this struggle for liberty. But the foremost ranks need strength and support in depth.

This is a battle to continue the philosophy of the men and women who came to our shores in 1607 to obtain freedom—economic as well as religious liberty. The statesmen who founded our government designed a form of government based on individual freedom and personal responsibility for all citizens. No matter how one looks at it, those early decisions as to the proper functions of government have proved to be the most effective the world has ever known.

Yet there persists the idea that state-guaranteed "security" offers something better. The promise of the tempters has been the same throughout the ages: "Give us your money and we will manage everything for your own good." In that principle there is nothing but disillusion. It saps strength and character by placing a premium on greed and weakness. It destroys the individual's responsibility for self-help, respect, compassion, and charity.

The annual meeting in San Francisco is more than a chance to replenish your store of scientific knowledge. It is an opportunity to reaffirm the faith of our forefathers in the true virtues of free men.

John Wm Truitt MD

Minutes of the Council Meeting, Madison, February 18-19, 1950

1. Call to Order

The Council was called to order by Chairman Arveson at 3:00 p.m., Saturday, February 18, 1950, at the Society's office, Madison.

2. Roll Call

Councilors present were Doctors Eck, Hemmingsen, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Christofferson, Arveson, Ekblad, Galasinski, Howard, Wegmann, Leahy (Saturday only), Past-President Doege, and Chairman Emeritus Gavin.

Also present were President Truitt; Speaker of the House Stewart; Treasurer Sisk (Saturday only); Vice-Speaker MacCornack; Delegate to the A.M.A. Stovall; Dr. J. S. Supernaw, chairman of the Veterans Medical Service Agency; Dr. R. E. Fitzgerald, chairman of the Commitee on Grievances; Dr. C. N. Neupert, state health officer; Dr. R. C. Parkin, director of "March of Medicine" radio programs; Secretary Crownhart; Assistant Secretary Ragatz; Mr. T. J. Doran, director of the Veterans Agency; Mr. R. F. Weber, director of Wisconsin Physicians Service; Mr. Earl Thayer, director of public relations; Mr. Robert Murphy, legal counsel; Miss Helen L. Brandt and Miss Leona Kellerman of the Society's office.

Besides Doctor Christofferson, members of the Wisconsin State Board of Medical Examiners who were present at Saturday night's meeting were Drs. J. W. Smith, E. W. Miller, A. G. Koehler, E. C. Murphy, and J. W. Prentice. Mr. John Davison, attorney for the Board, was also present.

3. State Board of Medical Examiners

Members of the State Board of Medical Examiners were invited to meet with the Council to explain the problem and the Board's position relative to the licensing of physicians who have secured their education in foreign schools.

Discussion was participated in both by councilors and by members of the Board, following which Chairman Arveson appointed Doctors Bell, Fox, Kasten, and Mr. Crownhart as a committee to meet separately with Doctors Miller, Smith, Murphy, and Mr. Davison, representing the State Board, for the purpose of developing a summary statement of the discussion.

The following statement was submitted by this group for consideration of the Council, and on motion of Doctors Ekblad-Wegmann, carried, it was approved:

The Council believes that the State Board of Medical Examiners has acted not only in entire good faith in the matter of reviewing qualifications of those educated in foreign countries, but that the Board is to be particularly complimented on the fact that it has been the moving influence bringing about a study which just recently reported evaluation and approval of some 38 foreign schools, with further reports to be made as rapidly as studies can be conducted.

In the face of such a constructive record it is unfair to accuse the Board of trying to build a fence around medical practice in Wisconsin. The Board consists of highly respected individuals, many of whose immediate forebears come from foreign countries. If they have done any "fence-building," it is that as a state agency, not responsible to any other group but the public through its legislative and judicial processes, it has consistently and properly sought to protect the health of the people of this state.

There is no valid reason to try to telescope a most important program of foreign medical school evaluation into a matter of a few weeks or months. If the Board of Medical Examiners were to respond to some of those importuning it to act, the Board would be making a mockery of the evaluation study.

The Council anticipates that the State Board of Medical Examiners at its next meeting, to be held in April, will accept the national report on foreign schools and will continue to accept those reports as made.

Members of the State Board present at the meeting stated that the policy of the Board will be to accept for examination graduates of those schools which have received approval of the national accrediting body. In addition, the members of the State Medical Board stated that it will continue in the future to receive applications from graduates of schools not as yet formally qual fied and expect the applicant to fulfill his unquestioned legal responsibility of showing evidence that his training was in a reputable medical school, and was equivalent to that required in the medical school of the University of Wisconsin.

He should submit more than photo-copies of certificates of graduation. He should submit details as to his premedical training, the course offered by the school, its teachers and their records, and the kind of physical plant.

He should demonstrate that he was trained, in part at least, by methods other than lectures, mimeographed or oral. He should know the laws of this state pertaining to dispensing of dangerous drugs, to the use of narcotics, and those pertaining to public health such as quarantine and the like.

Only then will the Board be in a position to review such material, and to ask the assistance of national agencies, including the Council on Medical Education of the American Medical Association. The Council of the State Medical Society has instructed its sec-

retary's staff to render such assistance as it may be called upon to perform by the State Board of Examiners.

The Council has received several suggestions. One is the development of some form of educational license for those desiring residency training and the like. Another is that the State Board of Medical Examiners be given a power it does *not* now possess —that of considering such additional training as an applicant may have acquired since coming to this country. Both suggestions are referred to the Society's Committee on Medical Education for study and report to the House of Delegates in October 1950.

In the meantime, the Council warns that this problem is nothing with which to trifle. Sound health depends on sound training and knowledge. There will always be exceptions to a rule but that is no argument against the soundness of the rule.

4. Approval of the Minutes

On motion of Doctors Hemmingsen–Ekblad, carried, minutes of the October 1–2, 1949, meeting of the Council, as published in the November 1949 *Wisconsin Medical Journal*, were approved.

5. Councilor District Reports

Reports of the councilors on activities in their respective districts were received.

6. Report of the State Health Officer

Doctor Neupert, state health officer, reported that less emphasis had been given to control measures such as placarding and quarantine in communicable diseases, with more stress being placed on isolation and reporting in an effort to modernize communicable disease regulations. He also reported on the status of activities under the Hospital Survey and Construction program, and that a subcommittee of the Council on Scientific Work of the State Society had worked effectively with the University of Wisconsin, State Board of Health, and voluntary agencies to coordinate the various fields of postgraduate education, such as the spring clinics. He stressed the value of increased facilities for the State Laboratory of Hygiene which is currently operating under space allocations established in 1928.

Doctor Neupert stated that in 1946 there were over 74,000 live births, 101 mothers died in childbirth, and the rate per thousand live births was 1.4 per cent. This figure had dropped to the point where in 1949, with over 80,000 births, the number of maternal deaths was estimated at 50, with a percentage of only 0.6 per thousand live births. Ninety-nine and nine-tenths per cent of the babies delivered were delivered by practicing physicians in Wisconsin, and practically all of them were delivered in hospitals, with the remaining number being delivered by neighbors.

On motion of Doctors Galasinski–Christofferson, carried, the Council commended the state health officer for his report and asked that the information it contained be released to the press.

7. Annual Meeting of the Council

The Interim Committee recommended to the Council that the annual meeting of the Council be held in February each year instead of January and that an amendment to the By-Laws be offered to change this provision. This recommendation was made because it has been difficult to close the financial records of the Society before the end of January and to present an adequate budget for consideration in the first month of the year.

On motion of Doctors Howard–Christofferson, carried, this recommendation was approved.

8. Research Council for Economic Security

The Research Council for Economic Security had asked the Society for financial support. This organization is responsible for the preparation of all kinds of material and information concerning ramifications of social security, and its offices have been called upon from time to time for information on its studies.

On motion of Doctors McCarey–Leahy, carried, the Council approved an appropriation of $100 for support of this economic service for one year.

9. Auxiliary Leaflet

The suggestion had been made that a more effective method of reaching the Auxiliary would be provided if information of interest could be sent to its members through its own publication four times a year, rather than to continue its page in the *Journal*. Addressograph plates could be provided at a cost of approximately $125. The publication had been drafted and submitted to the Auxiliary, which was enthusiastic in its opinion that the publication be accepted.

On motion of Doctors Dessloch–Ekblad, carried, the Council approved the proposed publication for the Auxiliary.

10. Election of Officers

a. *Chairman of the Council*—Dr. V. E. Ekblad, assumed the chair for this order of business. On motion of Doctors Fox–McCarey, carried, Dr. R. G. Arveson was unanimously re-elected chairman of the Council for the ensuing year.

b. *Treasurer*—On motion of Doctors McCarey–Ekblad, carried, Dr. I. R. Sisk was unanimously re-elected to serve as treasurer for the ensuing year.

c. *Secretary*—On motion of Doctors Hemmingsen–Wegmann, carried, Mr. C. H. Crownhart was unanimously re-elected secretary for the ensuing year.

On motion of Doctors Ekblad–Heidner, carried, a standing vote of appreciation was given to Mr. Crownhart for his efforts in the state and nationally during the past year.

11. Election to Interim Committee and Voting Powers

The term of Dr. H. H. Christofferson expired at this time, although he remained as an ex-officio member of the Interim Committee in his capacity as president-elect. On motion of Doctors Eck–Dess-

loch, carried, Dr. J. M. Bell was elected to the Interim Committee for a three year term.

On motion of Doctors Ekblad–Hemmingsen, carried, the following resolution was approved by the Council:

WHEREAS, the resolution creating the Interim Committee established two classes of members, namely those elected by the Council and those who serve ex-officio, and

WHEREAS, the result of such organization of the committee is that while responsibility for its many and important decisions rests on the entire committee, only a minority may vote on such decisions,

Be it resolved that, effective upon the passage of this resolution, voting power be placed in all members of the Interim Committee, whether elected or ex-officio.

On motion of Doctor McCarey, variously seconded, the president, president-elect, chairman of the Council, and chairman emeritus were named ex-officio members of the Interim Committee.

12. Report of The Treasurer

Doctor Sisk, treasurer, made the following report, which was approved on motion of Doctors Christofferson–McCarey, carried:

THE STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
REPORT OF DR. IRA R. SISK, TREASURER
For the Year Ended December 31, 1949

Cash on Deposit—First National Bank, January 1, 1949		$ 1,647.72
Receipts		
Membership Dues	$135,530.54	
1949 Exhibit Space Rentals	10,992.50	
Panel Receipts—Wisconsin Plan	512.50	
Round-table Receipts	3,664.00	
Postgraduate Clinic Receipts	3,014.25	
Interest Received	183.96	
Principal Collected on Aetna Insurance Policy	1,004.40	
Partial Payment of Advance—Wisconsin Veterans Medical Service Agency	7,500.00	
Total Receipts		162,402.15
Total		$164,049.87
Disbursements		
Constitutional Officers and Committees		
President	$ 500.00	
Council and Committees	9,763.74	
Books and Periodicals	901.35	
Auxiliary	200.00	
Secretary's Salary	12,500.00	
Secretary's Travel	2,873.88	
Group Total	$ 26,738.97	
Organization—Staff		
Assistant Secretary's Salary	8,400.00	
Assistant Secretary's Travel	951.46	
Executive Staff	14,883.00	
Group Total	$ 24,234.46	
Administrative Expenses		
Accounting and Insurance	4,030.37	
Social Security and Unemployment Compensation Taxes	909.10	
Office Rent	4,200.00	
Telephone and Telegraph	1,556.87	
Current Supplies	2,033.81	
Postage and Printing	4,580.78	
Fixtures and Upkeep	1,061.17	
New Equipment	2,379.69	
Miscellaneous	1,409.05	
Group Insurance	371.70	
Group Total	$ 22,532.54	
Totals—carried forward	$ 73,505.97	$164,049.87
Totals—brought forward	$ 73,505.97	$164,049.87
Membership—Special Service		
Legal	2,544.50	
Bulletins to Members	431.02	
Blue Book Issue	750.00	
Group Total	$ 3,725.52	
Public Health—Normal Service		
Hygeia	316.25	
Lay Publications	31.74	
Special Bulletins	327.79	
Telephone and Telegraph	264.14	
Legislative Counsel	2,000.00	
Veterans Medical Care and Prepaid Medical Care Plans	5,134.49	
Group Total	$ 8,074.41	
Public, Industrial and Rural Health and Public Instruction		
Wisconsin Plan Director	1,200.00	
Executive Director—Public Information	5,200.00	
Staff Salaries	5,294.38	
Executive Director and Staff Travel	1,903.90	
Press Releases	562.09	
Radio Programs	4,730.18	
Industrial Panels of Physicians	1,251.08	
Miscellaneous	268.51	
Group Total	$ 20,410.14	
Annual Meeting Postgraduate Clinics, County Medical Research Projects, and Wisconsin Medical Journal		
Annual Meeting	15,008.88	
Postgraduate Clinics	3,549.45	
County Medical Research Projects	254.50	
Wisconsin Medical Journal	2,500.00	
Group Total	$ 21,312.83	
Other Expenditures		
Interim Appropriations	6,566.57	
Appropriations to State Medical Society of Wisconsin—Building Fund	10,040.72	
Appropriation to Secretary's Working Fund	500.00	
Group Total	$ 17,107.29	
Total Disbursements		144,136.16
Cash on Deposit—First National Bank, December 31, 1949		$ 19,913.71

13. Report of the Secretary

Mr. Crownhart reported that it was anticipated that in 1950 and 1951 a greatly expanded program would be promoted for Blue Cross, Blue Shield, and prepaid insurance, with consequent increases in enrollment in these voluntary programs.

He stated that the Wisconsin Society and its activities are integrated with those of the American Medical Association. Dr. J. S. Supernaw has been appointed to the Correlating Committee on Veterans' Care of the Council on Medical Service of the American Medical Association; Dr. R. E. Fitzgerald was elected secretary and next year will become president of the National Conference on Medical Service; the secretary has been serving in a secretarial capacity to the Committee on Consumer-Sponsored Programs of the Council on Medical Service; and the Wisconsin delegates to the American Medical Association, Doctors Stovall, Gavin, and Sargent, are very active. The American Medical Association had been billed for the cost of collecting the special assessment in 1949, and the bond of the secretary and assistant secretary had been increased to $50,000 so as to protect both the American Medical Association and State Society with the increase in moneys passing through the Society's office for the A.M.A. dues this year.

The staff is busy with committee activities, writing up minutes, handling speaking engagements, and the like. There are forty to fifty meetings held during the course of a year.

On motion of Doctors Christofferson–McCarey, carried, the report of the secretary was approved.

14. Report of the Veterans Medical Service Agency

Dr. J. S. Supernaw, chairman of the Operating Committee of the Veterans Agency, presented the following statistics and certified financial statement relative to the Agency:

WISCONSIN VETERANS MEDICAL SERVICE AGENCY

Statistics for the Year 1949

The committee of the Wisconsin Veterans Medical Service Agency wishes to present a report of the Agency activities for the year 1949.

Total value of authorizations received from Veterans Administration	$293,822.75
Total value of claims filed with Veterans Administration	237,021.94
Total amount of checks written to 1,072 physicians	222,348.66
Total value of unused authorizations (3 office visits authorized and only 2 used and similar cases)	50,023.31
Total value of authorizations cancelled (Authorities issued but no services rendered)	22,528.89
Total number of Forms 100 received (Requests for authority to treat veterans)	1,879.00
Total number of Forms 200 received (Claims for services by M.D.s average of 1,438 per month)	17,256.00

WISCONSIN VETERANS MEDICAL SERVICE AGENCY

Madison, Wisconsin

CERTIFIED FINANCIAL STATEMENT

December 31, 1949

Assets		
Current Assets		
Cash in Bank—Administrative Fund	$ 3,335.20	
Cash in Bank—Medical Fund	1,978.50	
Petty Cash	10.00	
Medical Claims Filed with Veterans Administration	11,406.24	
Administrative Claim Filed with Veterans Administration	2,340.97	
Unfiled Claim for Administrative Expenditures	219.06	
Total Current Assets		$ 19,309.97
Fixed Assets		
Office Furniture and Fixtures	$ 2,451.04	
Less: Accumulated Depreciation	791.41	
Total Fixed Assets		1,659.63
Prepaid Expenses		
Unexpired Insurance		106.20
Total Assets		$ 21,075.80
Liabilities		
Current Liabilities		
Due Doctors on Claims Filed	$ 13,384.74	
Accounts payable	219.06	
Total Liabilities		13,603.80
Advance from State Medical Society of Wisconsin		
Balance Cash Advanced—July 1, 1949	$ 15,000.00	
Additional Advances	1,500.00	
	$ 16,500.00	
Amounts Repaid	9,000.00	
Balance of Cash Advanced—December 31, 1949	$ 7,500.00	
Less: Non-recoverable Expenditures	28.00	
Total Advance—December 31, 1949		$ 7,472.00

CERTIFICATE

I have audited the accounts of the Wisconsin Veterans Medical Service Agency, an agency of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period July 1, 1949 to December 31, 1949, and

I hereby certify that, in my opinion, the above Financial Statement and related statement of Income and Expenditures correctly presents the financial condition of the Agency on December 31, 1949 and the result of its operations for the period July 1, 1949 to December 31, 1949, in conformity with generally accepted accounting principles.

Madison, Wisconsin /s/ DONALD E. GILL
January 24, 1950 *Certified Public Accountant*

Doctor Supernaw expressed his appreciation to Mr. Doran, director of the Agency, for the excellent manner in which he has carried out his responsibilities.

The following specific recommendations were made: Because of the large volume of business transacted by the Agency, and the many regulations involved, it may seem advisable to the Directing Committee that there be certain "spot" audits to assure compliance with established procedures. The chairman, after discussing the matter with the Directing Committee, suggested that the committee be permitted, if it so determines, to provide for such audits, and if the costs are not recoverable, it be permitted to charge the costs (not to exceed $1,500) against the State Medical Society general operating fund as a credit against the advance now debited the Agency.

On motion of Doctors Howard–Christofferson, carried, authority was confirmed in the committee to handle such problems and to take such action as might be feasible.

On motion of Doctors Bell–Dessloch, carried, the Council appropriated $1,500 to the Operating Committee for this purpose.

15. Report of Wisconsin Physicians Service

Dr. E. M. Dessloch, chairman of the Directing Board of Wisconsin Physicians Service, presented a report of operations and statistics from December 1, 1946 through December 31, 1949, showing 66,777 contracts and 157,930 persons covered as of January 1950. As of February 1, he reported an increase to 67,844 contracts, and 160,539 persons covered.

As of December 31, 1949, $1,369,822.25 in service benefits had been paid.

On motion of Doctors Christofferson–Eck, carried, the report submitted in full by Doctor Dessloch was approved.

Doctor Dessloch also reported that Wisconsin Physicians Service had retained Mr. Donald Gill as its accountant and Mr. Robert Murphy as its counsel for the year of 1950.

It submitted the following resolution with regard to dissolution of Wisconsin Physicians Service, and it was noted that dissolution, while not contemplated at present, should be arranged for in case of such eventuality:

Resolved, by the Council of the State Medical Society of Wisconsin that since it was the intent of the Society in creating Wisconsin Physicians Service that if the program of that agency should at any time be liquidated, none of the funds in the account of the agency, other than those necessary to discharge its obligations, should accrue to the benefit of the State Medical Society of Wisconsin or of any of its members, therefore

Be it further resolved, that if it appears that funds of Wisconsin Physicians Service, as an activity of the State Medical Society of Wisconsin, not otherwise required to discharge its obligations in event of its liquidation, would be those of the Society, then it is declared that any such funds shall be placed at the disposal of the University of Wisconsin for the purpose of furthering the development of the Wisconsin Continuation Center;

Be it further resolved, that if the laws of this state do not clearly provide for the liquidation of such plans as Wisconsin Physicians Service, then the Directing Board of that program recommend to the Committee on Public Policy legislation appropriate to that purpose, and

Be it finally resolved, that until such legislation be determined, this resolution shall be irrevocable except for the purpose of making it more legally effective in intent, should that be necessary.

On motion of Doctors Christofferson–Ekblad, carried, the resolution was adopted.

The meeting then recessed at 10:35 p.m. until 9:15 the following morning.

16. Reference Committee Chairmen

The Interim Committee recommended to the Council that the chairmen of reference committees of the House of Delegates meet with the Interim Committee a month before the Annual Meeting and with the Council at the meeting just preceding the House of Delegates.

On motion of Doctors Kasten–Christofferson, carried, this recommendation was approved.

17. Handbook for Annual Meeting

The recommendation was made that a pocket-sized handbook be prepared for delegates, to be distributed thirty days in advance of the Annual Meeting containing committee recommendations, composition of the House of Delegates, and the like.

It was moved by Doctors Christofferson–Eck, carried, that this recommendation be approved.

18. Wisconsin Plan Committee Increased

The Interim Committee recommended to the Council that the Wisconsin Plan Committee be increased to nine members so as to conform in number with the committee of Wisconsin Physicians Service.

On motion of Doctors Ekblad–McCarey, carried, the Wisconsin Plan Committee was increased to nine members.

19. Recommendations of Council on Scientific Work

The following recommendations of the Council on Scientific Work were referred to the Council:

a. *Residents*—All residents, irrespective of whether they carry a resident membership, be admitted as guests of all scientific affairs of the Society (clinics, councilor district meetings, and the Annual Meeting).

b. *Veterans Administration*—The present requirements for admittance apply, with the exception that when a scientific exhibit is prepared by the Veterans Administration at the request of the Council on Scientific Work, those Veterans Administration members who will be identified with the exhibit and whose presence would be desirable to interpret the exhibit be admitted as guests. This would be determined only by correspondence with the member who would be identified with the scientific exhibit involved.

c. *Hospital Personnel*—The present practice be followed of securing advance certification from hospital superintendents, but in cases in which the hospital superintendent fails to comply and a person presents himself or herself for admittance and can show proper identification with the hospital, such a person be admitted as a guest.

d. *Others*—If a physician member wishes to have his technician or office girl admitted, guest privileges should be extended upon written notice from the physician member.

On motion of Doctors Christofferson–Heidner, carried, these recommendations of the Council on Scientific Work were approved.

e. *Presentation of Paper on Nephritis*—The Council on Scientific Work asked that the rule which applies to the length of time in presenting a paper at the Annual Meeting be extended to permit Dr. Francis Murphy thirty minutes instead of twenty for the presentation of a paper on acute nephritis, on the opening day of the meeting.

On motion of Doctors Heidner–Christofferson, carried, this recommendation was approved.

f. *Secretary's Office to Coordinate Postgraduate Education*—The Council on Scientific Work appointed a Coordinating Committee on Postgraduate Education to prepare a program of postgraduate education beginning in 1951 in an effort to develop a more comprehensive program for the physicians in the state by way of developing circuit teaching programs. These programs would extend over eight to ten weeks each year and would be coordinated with the continuation courses offered at Marquette and the University of Wisconsin medical schools. The Council on Scientific Work asked that the Council authorize the secretary's office to serve as coordinator for the expanded program in carrying out the administrative details.

On motion of Doctors Wegmann–Bell, carried, the Council approved this recommendation.

g. *Program Chairman to Attend Mid-Winter Conference of American Medical Association.* The Council on Scientific Work further re-

commended that the program chairman who plans the scientific program for the next year's Annual Meeting be sent to the midwinter clinical conference of the American Medical Association. as an official representative of the Society.

On motion of Doctors Doege–Heidner, carried, this authority was given.

h. *Public Meeting in 1950*—Because the public meeting at the time of the 1949 Annual Meeting was well attended and enthusiastically received, the Council on Scientific Work suggested that a public meeting be continued, but because of the full schedule of the program, it was suggested that for 1950 the Smoker on Monday evening be dispensed with, and a public meeting be arranged in the Sports Arena of the Milwaukee Auditorium, with a good speaker obtained.

On motion of Doctors Christofferson–Heidner, carried, action on the decision whether to have a public meeting in place of a Smoker was delayed until the next meeting.

20. Retirement Plan

The Interim Committee asked that details on a retirement program for Society employees be sent to the Council prior to its February meeting. The Council reviewed this program and referred the matter to the Interim Committee for a determination as to its costs.

21. Committee on Medical Education and Hospitals to Study Medical Practice Act

Individuals representing the pathologists had suggested the need for re-examination of those laws relating to medical licensure, expressing concern over the development of clinical pathologic laboratories under lay control. As this problem embraces a larger field of activity than clinical pathology alone, the Council recommended that the president of the Society be authorized to appoint a special committee to study the entire Medical Practice Act, its adequacy, and its relationship to various fields of specialized practice, the committee to report its recommendations to the next session of the House of Delegates.

As this matter was not acted upon by the Reference Committee on Reports of Officers at the 1949 House of Delegates, the Interim Committee asked that it be referred to the Council for action.

Doctor Truitt stated it was his belief that this matter should be referred to the Committee on Medical Education and Hospitals for study and report back to the House of Delegates, rather than to establish a new committee.

On motion of Doctors Dessloch–McCarey, carried, the Council approved Doctor Truitt's suggestion.

22. Shortage of Physicians and Resolution of Section on Radiology to be Studied by Committee on Medical Education and Hospitals

The subject of shortage of physicians was discussed by the Interim Committtee, it being pointed out that there was much prevalent belief to the effect that the medical profession, through the medical schools, operated some sort of quota system to hold down enrollment of medical students. This subject was referred to the Council, with the suggestion that the entire subject be reviewed by the Committee on Medical Education and Hospitals and that such constructive steps as are indicated be reported to the Council.

At the time of the House of Delegates meeting in 1949, a resolution of the Section on Radiology was referred to the Reference Committee on Reports of Standing Committees, which made the following comment concerning it in its report:

In regard to the resolution from the Section on Radiology, this committee was impressed with the far-reaching potentials, and did not feel capable of making recommendation upon the resolution, but recommended that it be returned to the proper official of the State Medical Society, with a recommendation that he cause an extensive study to be made of this resolution and its implications.

The resolution asked that the House of Delegates endorse action of the A.M.A. House in adopting the report of the Committee on Hospital and the Practice of Medicine (Hess Report). It is quoted in full below:

WHEREAS, the House of Delegates of the American Medical Association in assembly at Atlantic City, New Jersey, June 9, 1949, adopted the report of the Reference Committee on Reports of Boards of Trustees and Secretary, paragraph eight of which contained the report of the Committee on Hospitals and the Practice of Medicine (Hess Committee), and

WHEREAS, the House of Delegates of the American Medical Association thereby recommended to each of its component state and territorial societies that it appoint a Committee on Hospital and Professional Relations to receive, hold hearings upon, and adjudicate all complaints relating to professional and/or economic problems involving physicians and hospitals, and

WHEREAS, The State Medical Society of Wisconsin has for eight years had a Committee on Hospital Relations which has heretofore confined its activities and efforts to promoting the development of mutual understanding and amity between representatives of medical organizations and hospital organizations by sponsoring annual hospital-medical conferences, but has not heretofore been charged with the function of hearing and adjudicating disputes and/or complaints arising between physicians and hospitals regarding the practice of medicine in hospitals,

Be it hereby resolved, That the 1949 Session of the House of Delegates of the State Medical Society of Wisconsin in assembly at Milwaukee, October 4, 1949, endorse the action of the A.M.A. House of Delegates in adopting the report of the Committee on Hospitals and the Practice of Medicine (Hess Report) and hereby specifically charge the Committee on Hospital Relations of the State Medical So-

ciety of Wisconsin with the further duty of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen between a member of the medical profession and a hospital.

Be it further resolved, That if the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its judgment to that effect with its findings and recommendations shall be transmitted to the Council of the State Medical Society of Wisconsin, in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

On motion of Doctor Ekblad, variously seconded, and carried, the subjects of shortages of physicians and the resolution of the Section on Radiology were referred to the Committee on Medical Education and Hospitals with the request that that committee report to the Council prior to making its report to the House of Delegates.

23. Delegates to U. S. Pharmacopoeial Convention

Doctors Tatum and Beckman, co-editors of the "Comments on Treatment" page of *The Wisconsin Medical Journal,* had been designated as delegates to the U. S. Pharmacopoeial Convention. The question of payment of expense was raised, and the Interim Committee referred the matter to the Council, with the recommendation that the expense of the two delegates be paid.

On motion of Doctors Howard–Bell, carried, the Council approved paying the expenses of these delegates.

24. Admission of Non-Members to Scientific Sessions

The Interim Committee at its January meeting reviewed a communication from the secretary of the Eau Claire–Dunn–Pepin County Medical Society with regard to admitting members of the medical school faculties in the basic sciences to the scientific sessions of the State Society. The secretary's reply was also reviewed. The Interim Committee affirmed the secretary's letter as a proper policy and asked that both letters be placed before the Council for advice.

On motion of Doctors Dessloch–Ekblad, carried, the Council approved the secretary's letter which outlined the policy under which non-members are not admitted to scientific sessions.

25. Dr. R. S. Baldwin, Marshfield, New Medical Editor

Dr. K. H. Doege asked that he be relieved of the privilege of being medical editor for the *Journal,* and recommended that Dr. R. S. Baldwin be elected in his place inasmuch as Doctor Baldwin had had an opportunity to become well indoctrinated into the work. The Council noted that Doctor Doege is at present a member of the Directing Board of Wisconsin Physicians Service and appreciated that his responsibilities had been heavy during recent years.

On motion of Doctors Wegmann–Galasinski, carried, the resignation of Doctor Doege was accepted, and Dr. R. S. Baldwin was elected as the medical editor for a two year term.

The Council extended a rising vote of thanks to Doctor Doege for his yeoman service as medical editor during the last ten years.

26. Committee to Study Needs of Industry

At the 1949 session of the House of Delegates a resolution was adopted that the president of the State Society create a roving committee to examine into conditions and needs of industry in Wisconsin, with particular emphasis on the point of voluntary medical insurance.

It was recommended that the committee consider the resolution together with an outline with reference to its activity, but in addition that the committee be notified that the Council had not as yet established a budget for the roving committee's activity and that the Interim Committee suggested that before it consider conducting hearings throughout the state, it first consider the advisability of securing personal information through the use of questionnaires. If the committee then felt the need of holding actual hearings throughout the state, it should first meet with the Interim Committee and then seek approval of the Council to the necessary budget.

On motion of Doctors Kasten–Heidner, carried, the roving committee was authorized to conduct its study through questionnaires on an experimental basis.

27. American Legion

Dr. R. L. MacCornack reported that he had appeared before the Executive Committee of the American Legion and obtained the endorsement of this group on the National Education Campaign and approval of the Society's mailing requests to 575 American Legion posts in Wisconsin for resolutions in opposition to socialized medicine. Doctor MacCornack also reported that the Executive Committee of the American Legion requested an opinion from the State Medical Society to a bill in Congress, proposing to consolidate all federal medical activities, including those of the Veterans Administration, into a united medical administration. The American Legion was opposed to this bill and wanted to have the opinion of the medical profession on it.

On motion of Doctors Fox–Eck, carried, the Council asked that a letter be sent to the Executive Committee of the American Legion over the chairman's signature thanking it for its action in opposition to socialized medicine.

Doctor Arveson announced that he would refer the request for an opinion on the united medical administration bill to the Operating Committee of the Veterans Medical Service Agency.

28. Sheboygan County on Life Membership

The following communication was received from the Sheboygan County Medical Society with regard to life membership:

"At a regular meeting on January 12, 1950, the Sheboygan County Medical Society voted to protest the action taken by the State Medical Society in increasing the requirement for life membership from forty to fifty years. Inasmuch as a doctor is twenty-five or thirty years of age before he can begin to practice, it means that a doctor must be seventy-five or eighty years of age before he can become eligible for life membership.

"For practical purposes this deprives many doctors of an honor which is due them. It is the feeling of our Society that if financial considerations prompted this action, it is unfair to the older members who might otherwise be eligible, since a member who is sixty-five or over can hardly be expected to pay the present dues."

The State Society secretary advised the county society that life membership should be evaluated in light of the two provisions for associate and affiliate membership, pointing out that associate membership is intended for those who have completely retired from practice, and affiliate membership for those who, by reason of illness or some other circumstances are confronted with straightened financial conditions which would make the payment of dues a matter of personal hardship.

The Interim Committee referred these two letters to the Council for review. On motion of Doctors Heidner–Ekblad, carried, the letters were accepted.

29. Associate Memberships

a. On motion of Doctors Dessloch–Kasten, carried, associate membership was granted to Dr. R. M. Waters, formerly of Wisconsin General Hospital, and now living in Orlando, Florida. Doctor Waters is fully retired.

b. On motion of Doctors Wegmann–Howard, carried, associate membership was granted to Dr. E. F. Peterson, Wauwatosa, who has retired from practice.

30. Progress Report on Kenosha County Consumer-Controlled Program

A progress report was made on developments in a Kenosha County consumer-controlled insurance program. It was suggested that the Coordinating Committee on Prepaid Health Plans should master all of the details of this program, so that in event it is installed, that committee would have the responsibility of seeing that it is installed with the approval of the State Medical Society.

On motion of Doctors Howard–Heidner, carried, the Coordinating Committee on Prepaid Health Plans was asked to make a study of the Kenosha proposed program for the development of a consumer-controlled insurance program.

31. Osteopathic Resolution

The Interim Committee referred to the Council for its consideration a resolution on osteopathy as follows:

The last legislature with the concurrence of the officers, the public policy committee and the Council of our Society enacted legislation permitting unrestricted license to osteopaths under substantially equal education and training qualifications; schools of osteopathy must give courses similar and equivalent in quality and period of training to those given by the Medical School of the University of Wisconsin.

The legislation first introduced by the osteopaths was entirely objectionable to our group on the grounds of good methods of medical practice and the protection of the health of the public.

After long sessions with the osteopaths and their able attorney, they agreed that educational qualifications both premedical and medical substantially equal to that of students graduating from the University of Wisconsin Medical School were acceptable for an unrestricted license to practice medicine and surgery. This marked another epoch in the progress of medical care for the sick in this country. From the early days of our colonies, through the struggle to achieve national independence through pioneer development and the creation of a United States medical practice has been varied and marked by cultism. One by one these cults have been absorbed by orthodox methods of practice as their membership has grown to professional stature. Thus the osteopath has acquired professional recognition in our State as well as in several others. Now questions of ethics are raised.

1. Should Doctors of Medicine respond to requests to see patients in consultation with osteopaths holding an unlimited license in an osteopathic hospital?

2. Should Doctors of Medicine see their own patients when taken to an osteopathic hospital in emergencies?

The only question that is above the level of trade unionism is the moral responsibility for the welfare of the sick which the physician has accepted from the time of Hipprocrates. When the sick and suffering require his skill and his assistance he does not refuse.

The ethical question revolves around the adequacy of osteopathic treatment and the welfare of the patient. We cannot control the osteopath and the method of treatment which he prescribes for his patient; nor can we control the patient's choice.

Since physicians recognize osteopathy as a technic that is applicable to only one branch of medicine, physical medicine, it cannot be accepted as a system of medicine for the care of sick.

Applicable in this regard is Chapter 3, Article 6, Section 2 of the Principles of Medical Ethics:

> "A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care."

Since osteopathy is not recognized as an over-all method for treating the sick, the question here to be decided is whether adequate treatment can be administered under the circumstance. This decision is an individual one and must be made in each instance.

Chapter 2, Section 4 of the Principles of Medical Ethics, is applicable to the ethics of consulting with osteopaths in an osteopathic hospital.

"A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant."

No rule governing all cases and no categorical statements can be made. The good judge of the Doctor of Medicine and the circumstances surrounding each case must be relied upon to decide individual cases.

The Council, therefore, does not believe that a rule on the ethics of all cases can be expressed but it does wish to offer the following opinion. Invitations to consult with osteopaths holding an unlimited license should be accepted only in dire emergencies. Once the emergency is satisfied, the M. D. should withdraw from the case unless the patient expresses the desire to have the doctor of medicine continue in charge and the patient is transferred to a hospital of his choice. If a patient of a doctor of medicine is taken to an osteopathic hospital as an emergency, the M. D. should treat the patient under these circumstances for the duration of the emergency.

Because the public may interpret the appearance of members of the State Medical Society on the program of osteopathic groups and societies as an endorsement of osteopathy as a system of medicine, the Council advised against and does not sanction this procedure.

Dr. W. D. Stovall made a report on inquiries received from other states on this matter and the development of the osteopathic law in Wisconsin.

On motion of Doctors Kasten–Galasinski, carried, Doctor Stovall's report was accepted.

It was further suggested that the secretary's office write the Council on Medical Education and Hospitals of the American Medical Association with regard to this matter and with the request that it set up a method of accrediting osteopathic schools. On motion of Doctors Ekblad–Heidner, carried, this recommendation was approved.

32. Report of Committee to Study Group Insurance

Since making its report to the Council in October 1949, this committee prepared specifications for a proposed disability contract to be offered the general membership of the Society. These specifications were mailed to approximately 100 insurance companies licensed by the state of Wisconsin in the disability field. Seven proposals were submitted. Council action was asked on the following points:

a. Approval of the revised specifications submitted to each councilor.

b. Permission to submit the revised specifications to three of the seven companies which evidenced interest. The other four companies were omitted either because they expressed unwillingness to write one or more of the coverages deemed essential, or for other reasons deemed sufficient by the committee.

c. Approval to retaining the firm of Marsh and McLennan, insurance analysts and brokers, as brokers of the Society for any group disability insurance program adopted by the Society. That firm would be compensated entirely by the insurance company, but would act as agents for and without cost to the State Medical Society.

d. In event these points were approved, the committee asked that its insurance program be publicized in the *Medical Journal* and through announcements to all county medical societies.

e. The committee be continued by the Council to assist in administering claims and in negotiating broader benefits after the contract has had a chance to function for a time. It was believed the committee should have such authority as is consistent with whatever functions may be delegated to it by the Council.

On motion of Doctors Bell–Wegmann, carried, the Council approved the committee's report and recommendations.

33. Recommendations of Coordinating Committee on Prepaid Health Care

This committee made the following recommendations to the Council:

a. Final approval to the fee schedule, previously tentatively approved in October 1949. Subsequent changes reconcile terminology, eliminate items listed without amounts, and reconcile items previously listed with a variable fee. On motion of Doctors Bell–Wegmann, carried, this recommendation was approved. A roll call vote was taken, with the result that ten were in favor, two opposed, and six absent.

b. Approval to designating spinal barbitage as a surgical procedure, not to be listed in the printed schedule at this time: fee, $50. On motion of Doctors Ekblad–Eck, carried, Doctor Parkin was asked to obtain information with regard to this procedure and present it at the next meeting.

c. Authority be given to secure such actuarial advice as is necessary for a statistical study of the fee schedule and its application to Wisconsin Physicians Service and the Wisconsin Plan. On motion of Doctors Dessloch–Fox, carried, this recommendation was approved.

d. Continuation of employment of Dr. Robert C. Parkin as medical director for Wisconsin Physicians Service and the Wisconsin Plan, compensation of $100 monthly to be divided equally between accounts of the central office and Wisconsin Physicians Service. On motion of Doctors Dessloch–Bell, carried, this recommendation was approved.

e. Reported its study of the problem of "double" coverage (insured having more than one policy providing benefits for identical circumstances); its study of appropriate ceiling limitation on the liability of Wisconsin Physicians Service; appropriate procedures to enable covered persons to represent actual income at the time of asking for service covered; its settlement of disputed claims, as referred by the medical director and the two prepaid programs; a special study of obstetric benefits under both plans in relation to the full coverage features, and its conference with a special committee of the Wisconsin Obstetrics Society on this matter. No action was necessary on this item.

34. Report of Committee on Audit and Budget

The following report was made by the Committee on Audit and Budget:

This committee of the Council reports that it has completed its audit of Society accounts for the year 1948 and finds the records to be in order with proper support for checks issued. The operating report of *The Wisconsin Medical Journal* was submitted by our accountant, and the committee reviewed it in detail.

While not part of the current audit, the committee reports with satisfaction that the direction of the House of Delegates will be complied with to the effect that funds be set aside from 1949 dues receipts so that the Society might begin re-establishment of its reserves.

The committee recommends, with the approval of the treasurer, that the office begin the use of a new form of check on which the purpose for which issued may be shown on the check itself. It is appreciated that this will cause more detail work within the office, but with the growth of activities, such a procedure now seems advisable.

The committee commends the treasurer for his work. He follows Society fiscal affairs closely, and his work is of the competence he has demonstrated since he has assumed the office. The committee has reviewed the Society budget for 1950, as submitted by the secretary and suggested several changes to him. As submitted to the Council with this report, it has the committee's approval.

On motion of Doctors Hemmingsen–Ekblad, carried, this report was approved.

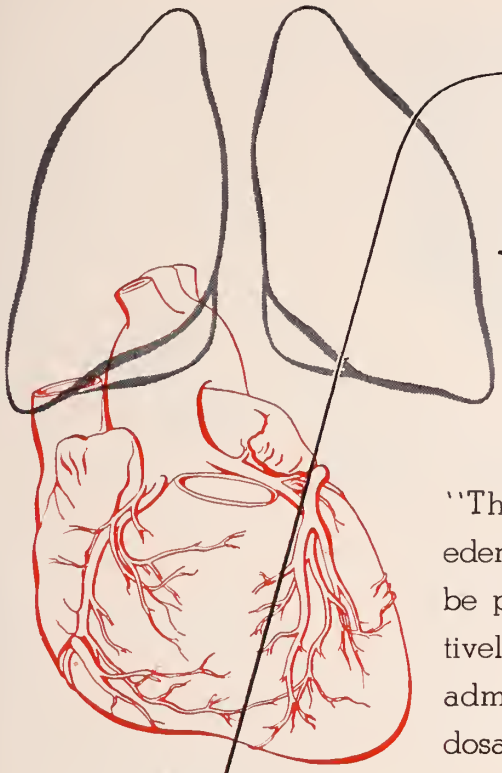
35. Budget for 1950

The budget, as reviewed item by item, and approved by the Council for the year 1950 follows:

1950 BUDGET

Budget Item	*Appropriation*
1. *President's Travel*—This has been a standing appropriation of some years and avoids necessity of vouchering costs, etc.	$ 500.00
2. *Council and Committees*—This appropriation covers cost of the five meetings of the Council, monthly meetings of its Interim Committee, the meetings of the Society's numerous committees, travel expenses of the three A.M.A. delegates to two yearly meetings of the A.M.A., and official attendance at many other meetings. *If all costs were billed, more than double this amount would be necessary.*	10,000.00
3. *Books and Periodicals*—Supplied to officers and councilors, and various members of committees—material assisting in effective discharge of official duties	750.00
4. *Auxiliary*—This is a nominal appropriation of some years' standing to aid the Auxiliary in its organization activities	200.00
5. *Secretary's Salary*—A bonus is not given to executives, but only to the secretarial staff.	14,500.00
6. *Secretary's Travel*—Attendance at A.M.A. meetings, and various national meetings as well as most of the committee meetings held by the Society	2,800.00
7. *Assistant Secretary, Salary*	9,000.00
8. *Assistant Secretary, Travel*	750.00
9. *Executive Staff*—This appropriation covers the salaries of an executive assistant, the office manager, a membership clerk, and two general duty secretaries. It includes amounts necessary to continue current bonuses, and allows less than $400 for adjustments during periods of new employees overlapping terms of employees leaving the Society, merit increases, etc.	15,900.00
10. *Accounting and Insurance*—Appropriation includes all Society insurance, audits, keeping books, filing various government reports, etc.	5,000.00
11. *Social Security and Unemployment Compensation Insurance*—This is the estimated contribution required under the several government laws affecting the Society	1,100.00
12. *Rent*—In previous years rent has been assigned to various activities. This practice has been discontinued within the Society's general budget. Total rent is now determined as $9,900. Of that, $1,200 is paid by the Journal, $3,300 by the Veterans Medical Service Agency, and $1,200 by Wisconsin Physicians Service. It should be emphasized here that rent includes the telephone line costs of approximately $1,400 annually paid by the building account.	4,200.00
13. *Telephone and Telegraph*—Line cost is carried out of the building fund account. This appropriation is for special service including toll charges	1,500.00
14. *Current Supplies.*—Costs of supplies are much higher. It is not possible to reduce this appropriation	2,000.00
15. *Postage and Printing*—This account carries cost of mailing membership certificates, general correspondence and the like. It appears to be the minimum, particularly with the much higher printing and similar costs of recent years	4,000.00
16. *Upkeep and Fixtures*—This account is chiefly one of maintenance and repair of typewriters, addressograph, mimeograph, etc. Addressograph handles 200,000 or more mailings annually	950.00

Budget Item	Appropriation
17. *New Equipment*—This account provides for new filing cabinets, at least one or two new typewriters, each year, and replacement of obsolete and worn out equipment. Slide projectors, a new adding machine, and a postage meter are needed in 1950	2,400.00
18. *Miscellaneous*—This allocation is for unanticipated items, such as an occasional extra bulletin, perhaps part-time help, etc.	1,500.00
19. *Group Insurance*—This provides Blue Shield and Blue Cross on all employees.	375.00
20. *Legal*—The normal legal expense has been held within an appropriation of $1,800 for some years. This covers advice to officers on legal liability and responsibility, miscellaneous inquiries of the membership constituting a matter of concern to the whole profession, committee activities and projects, etc.	1,900.00
21. *Bulletins to Members*—Within a similar appropriation, it used to be possible to carry four general membership bulletins each year. This appropriation allows three.	600.00
22. *Blue Book*—This has been an annual appropriation to the Journal to assist in carrying the increased costs of issuing the Blue Book edition of the Journal, which is furnished without cost to the junior and senior classes of the medical schools, and to new members. The Society is called on to furnish this volume to interested physicians and societies elsewhere as well. It is significant that the Indiana State Medical Association has recently undertaken the publication of a similar issue of its Journal	750.00
23. *Hygeia*—For many years the Society has issued gift subscriptions to this publication for various state officials and others in the public health field. One industrialist recently suggested that its circulation be greatly expanded.	400.00
24. *Lay Publications*—This is to cover cost of furnishing health studies and pamphlets to those passing on various public health procedures and policies, including surveys of physicians, etc.	600.00
25. *Special Bulletins*—This represents the minimum cost of periodic bulletins dealing with proposed changes in public health procedures and problems.	350.00
26. *Special Reports in the Journal*—Particularly during sessions of Congress and of the state legislature, these reports concern hearings and analysis of various proposals in legislation affecting distribution and quality of medical care.	300.00
27. *Telephone and Telegraph*—On matters pertaining to health legislation and the like. This represents overnormal costs of routine calls as contained in No. 13.	400.00
28. *Legislative Counsel*—There are many proposals, federal and state, and a considerable number are considered in the interim between legislative sessions. Counsel analyze these for the Society, and assist the secretary's office in representing views of Society in legislative halls. This appropriation is annual.	3,000.00
29. *Veterans Medical Care and Prepaid Medical Care Plans*—With Wisconsin Physicians Service steadily growing, as is true with the Wisconsin Plan, one full-time stenographic assistant is needed under this classification. New members must be reported to WPS and Veterans Medical Service, and enrollment procedures instituted. Each new year enrollment pamphlets are needed. Note further comment under each item.	
A. *Stenographic Assistant*	2,280.00
B. *Wisconsin Physicians Service*—This agency covers its own administrative expense, but certain Society expense in publicizing through the Journal and in cooperative assistance is necessitated and justifiable.	
C. *Wisconsin Plan*—Printing and other material costs in bulletins, etc.	
D. *Experimental Program*—The Price–Taylor County experiment in the prepaid medical care of the near indigent is still being conducted.	
E. *Veterans Medical Service Agency*—This is operated on a nonprofit basis by contract with the federal government. Within the total appropriation studies and conferences on matters not properly administrative costs may be made. It would include participation in studies of the state program as well.	1,800.00
30. *Wisconsin Plant Consultant*—Prior to organization of Wisconsin Physicians Service, this position was held by Mr. Weber and was created to give direction to the efforts of the Society in prepaid insurance, then chiefly the Wisconsin Plan. With organization of Wisconsin Physicians Service, Mr. Weber became its executive director. In 1949, Mr. Doran assumed management of Wisconsin Plan claim adjustment. The secretary continues as correlating administrator.	1,800.00
31. *Executive Director—Public Information*—This position is held by Mr. Thayer, whose function is to work with the Council on Medical Service and Public Relations. Coordination of press releases on Society activities, cooperation with newsmen, working contents of the Medical Forum, etc. are all within this field.	6,000.00



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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Barach, A. L.: Edema of the Lungs, Am. Pract. 3:27 (Sept.) 1948.

Budget Item	Appropriation
32. *Staff Appropriation*—This covers items numbered 31 to 37 inclusive. This account carries one full-time employee and one-half the salary of a second with the balance paid by the Journal. Two part-time employees (university students) are also carried out of this account.	4,800.00
33. 34. *Travel*—items 30–37 inclusive. This provides for traveling by the director of the "March of Medicine," Mr. Thayer, and contacts with radio stations.	1,700.00
35. *Weekly Press Releases*—These are distributed through the Wisconsin Press Association and consist of public health information to all newspapers in Wisconsin.	700.00
36. *Health Exhibits*—prepared for fairs, etc.	250.00
37. *Radio Programs*—25 Stations	
A. Honorarium to director, who spends three or four nights a week working up broadcasts, and about a day a week handling the correspondence from listeners. He is also available for talks before lay and professional groups. The 1949 appropriation was $1,800, only one-half being used because of delay in securing a successor to Doctor Cole.	1,800.00
B. Recording and discs	1,800.00
C. Supplies, express, and postage.	1,500.00
D. Printing	600.00
38. *Preparation of Panels of Physicians Available under Compensation Act*—Approximately 55,000 panels (printed by counties) are prepared. The budget is prepared on an annual basis for this project which involves a great deal of correspondence, forms, mailing and addressing.	
A. Applications and correspondence	200.00
B. Printing and distribution	1,700,00
C. Part-time help, postage and miscellaneous	400.00
39. Miscellaneous items from accounts 30–39 inclusive not anticipated, such as additional postage or part-time help, photograph slides, exhibit material, etc.	300.00
40. *Annual Meeting*—This appropriation is for costs in excess of income. The preprandial hour will be continued, as will the practice of paying expenses of technical exhibitors and speakers.	1,500.00
41. *Postgraduate Clinics*—The Society participates in twelve different clinics, but had the active and very real financial assistance of other groups. Were all costs to be borne by the Society, more than twice the amount budgeted would have been necessary.	2,200.00
42. *County Medical Research Projects*—These are encouraged by the Council on Scientific Work, which has requested moderate funds with which to provide some financial assistance, such as for a librarian or research worker. Results of these projects are to be brought to the annual meeting. Provision is made to encourage scientific programs at councilor district meetings. About $500 is necessary for this purpose.	600.00
43. *Wisconsin Medical Journal*—Costs in excess of advertising revenues.	3,000.00
44. *Interim Appropriations*—To this account are assigned those appropriations specifically made by the Council during the course of each year, and not properly chargeable to an existing budgetary allocation. No amount is shown in the budget for obvious reason that this account has the benefit of unused balances in other allocations.	
Note: If there are unused balances in items 10, 16, 17, 24–27 inclusive, and in items 37, 38, 40 and 41, these are continued as in the past. All other balances lapse.	
TOTAL	$120,655.00

36. Adjournment

The meeting adjourned at 3:45 p.m.

C. H. Crownhart,
Secretary.

Approved:

R. G. Arveson, M.D.
Chairman of the Council

INTERNS OF DULUTH HOSPITAL TO HOLD REUNION DINNER

Former interns at St. Luke's Hospital, Duluth, Minn., are invited to attend a dinner at the hospital at 6 p. m. on June 12, in connection with the meeting of the Minnesota State Medical Association at Duluth, June 12–14. Reservations may be made with Mr. James McNee, Superintendent, Saint Luke's Hospital, 915 East First Street, Duluth 5, Minnesota.

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MINNEAPOLIS MINNESOTA

Society Proceedings

Brown—Kewaunee—Door

A dinner meeting of the Brown–Kewaunee–Door County Medical Society was held at the Northland Hotel, Green Bay, on April 13. Dr. Harry D. Bouman, professor of physical medicine at the University of Wisconsin Medical School, was the guest speaker, discussing "Physical Medicine in General Practice."

Calumet

Members of the Calumet County Medical Society met at the Hotel Chilton in Chilton on March 23. The main topic of discussion was the small pox immunization which will be given to school children in Calumet this spring.

Douglas

Members of the Douglas County Medical Society heard memorials honoring two physicians of their group who recently died. The memorials read as follows:

DR. WILLIAM EDWIN GROUND

The attainment of success in one's chosen life work is the motivating force that is responsible for most worth while accomplishments. If that goal be reached over uncharted pathways, and by dint of the ingenuity that characterizes the true pioneer, then indeed is it singular and pre-eminent.

Such was true in full measure of the life of Dr. William E. Ground. And added to the ingenuity of the pioneer was an immense curiosity, and avid interest, and a limitless capacity for work. His mental processes, especially in his later years, belied his age; and it was given to him, as to few men, to reach the very threshold of ninety years, with his thinking accurate and keen.

He kept pace with the advances in his profession to the very end of his days. Possessed of a keen sense of humor and an incisive mind, his acquaintanceship was stimulating to all who knew him. He lived through and took part in some of the most amazing medical discoveries of all time and came to the termination of a long, an interesting and a useful life, still intent on what medical truths the morrow would bring.

To have known him was a privilege; we shall not see his like again. Robert Louis Stevenson's tribute to the physician seems to apply to him in a particular way:

> "There are men and classes of men that stand above the common herd; the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and, what are more important, Heraclean cheerfulness and courage."

DR. RUDOLPH E. CHRISTIANSEN

Pride of effort is a characteristic of every worth while calling to which men aspire. In the Law it is Justice; in the Ministry it is a Knowledge of the Supreme Being; in teaching, it is Truth; and in Medicine, it is Mercy.

It is perhaps given to no one except the physician to come as close to and share in the prerogatives of Divine Providence; as he does in the easing of pain and the conquering of disease.

In as much as we have lost a fellow physician, medicine is the poorer. And just as when the poet dies, some of his songs will remain forever unsung; so when a physician dies, some of the treasury of healing will be forever unspent.

Dr. Rudy Christiansen was not only a good physician in the sense of his ability and skill, he was also a good physician in the highest traditions of an honored profession.

He gave of himself to his patients; he gave of his talent to his associates; and he gave precious years of an all too short professional life, to the service of his country.

We who carry on after him are the richer for his having been one of us; and are the poorer for his passing.

Eau Claire—Dunn—Pepin

A dermatologist from Minneapolis—Dr. Carl W. Laymon—was the guest speaker at the April 24 meeting of the Eau Claire–Dunn–Pepin County Medical Society at the Hotel Eau Claire in Eau Claire. Doctor Laymon discussed "The Diagnosis and Treatment of Malignancies of the Skin."

A movie on "Breast Cancer–The Problem of Early Diagnosis" was shown at a meeting of the group on March 27, also held at the Hotel Eau Claire. Dr. Gordon Worley, Jr., associate professor of clinical pathology at the University of Wisconsin Medical School, discussed the subject of breast cancer, in connection with the showing of the film. *Dr. Julius Blom*, chairman of the cancer committee, reported on the desire of *Dr. A. L. Van Duser* and the State Board of Health for the establishment of a local cancer registry. Following a discussion, the motion to establish such a registry was tabled for the present.

"Idiopathic Pleural Effusion" was the subject discussed by Dr. William B. Tucker of Minneapolis at the February 27 meeting of the Society, also held at the Hotel Eau Claire. Doctor Tucker is an associate professor of medicine at the University of Minnesota Medical School. A motion was passed unanimously to go on record against President Truman's compulsory health insurance program, and *Dr. A. W. Hilker* was appointed chairman of the public relations committee which will contact various organizations in the city of Eau Claire and schedule short talks to acquaint their members with the pitfalls of compulsory health insurance as advocated by the President.

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bibliography: (1) Donovan, M. A.: New York State J. Med. *45*:1756, 1945. (2) Reaser, P. B., and Burch, C. E.: Proc. Soc. Exper. Biol. & Med. *63*:543, 1946. (3) Griggs, D. E., and Johns, V. J.: California Med. *69*:133, 1948. (4) Chapman, D. W., and Schaffer, C. F.: Arch. Int. Med. *79*:449, 1947. (5) Modell, W.; Gold, H., and Clarke, D. A.: J. Pharmacol. & Exper. Therap. *84*:284, 1945. (6) Finkelstein, M. B., and Smyth, C. J.: J. Michigan M. Soc. *45*:1618, 1946. (7) Gold, H., and others: Am. J. Med. *3*:665, 1947.

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Fond du Lac

Sunnyview Sanatorium at Winnebago was the meeting place for the Fond du Lac County Medical Society on April 27. A dinner was served to the group, with *Dr. G. L. Bellis* serving as host. "Lung Immobilization in the Treatment of Tuberculosis" was the subject discussed at the gathering.

The aims and functions of the State Medical Society were told to members of the Society at their March 23 meeting, held at Schreiner's Restaurant in Fond du Lac. Speakers were *Drs. J. W. Truitt*, Milwaukee, president of the State Medical Society, and *A. J. McCarey*, Green Bay, Sixth District Councilor.

Jefferson

Dr. J. W. Truitt, Milwaukee, president of the State Medical Society, discussed medical activities on a national and state level at the April 20 meeting of the Jefferson County Medical Society, held at the Green Bowl in Watertown. At the business session, *Dr. H. G. E. Mallow*, Fort Atkinson, chairman of the Committee for Revision of the County Welfare Department Fee Schedule, read the proposed changes; they were accepted by the Society.

Kenosha

Dr. Harvey S. Allen, assistant professor of surgery at Northwestern University Medical School, presented an illustrated talk on the care and treatment of burns to the Kenosha County Medical Society at a dinner meeting at the Elks Club in Kenosha on April 6. Doctor Allen is a member of the National Research Council on Burns and is attending surgeon at Cook County and Passavant Memorial Hospitals in Chicago. The Society went on record as favoring a federated health drive, which would incorporate all drives.

Outagamie

A guest speaker from Chicago—Dr. William F. Geittmann—was present at the February 16 meeting of the Outagamie County Medical Society at the Elks Club in Appleton to present a paper on "Ectopic Pregnancy." *Dr. G. W. Carlson* reported on the project of a bronze memorial plaque in memory of *Dr. E. F. McGrath.*

Dr. James Stack, Chicago, co-author of a book entitled "Fractures," addressed the Outagamie County Medical Society at a dinner meeting of the group held at the Elks Club in Appleton on April 20. Doctor Stack, who is associate professor of bone and joint surgery at Northwestern University Medical School and a surgeon at Passavant and Cook County Hospitals, Chicago, discussed "Amputation and Prostheses."

Pierce—St. Croix

Meeting at the Terrace in Somerset on March 21, members of the Pierce–St. Croix County Medical Society discussed management of acute conditions of the shoulder. At the business session a committee on fee schedules was appointed.

Shawano

A movie showing the value of proper nutritional methods in postoperative care was shown to the members of the Shawano County Medical Society at a meeting on March 21 at the Shawano Municipal Hospital. The film, prepared by E. R. Squibb and Sons, pharmaceutical company in New York, was shown by a representative of the firm.

Vernon

Dr. L. L. Sanford of Hillsboro was named president of the Vernon County Medical Society when the group held its annual election at Casperson's Cafe in Viroqua on April 19. *Dr. F. F. Gollin* of LaFarge was named vice-president; *Dr. C. A. Ender*, Viroqua, secretary-treasurer; *Dr. J. R. Richter*, Chaseburg, delegate; and *Dr. P. A. Leuther*, Hillsboro, alternate delegate. *Dr. James C. Fox* of La Crosse was a guest speaker at the meeting.

Washington—Ozaukee

Dr. Nathan Grossmann of Milwaukee was the principal speaker at a meeting of the Washington–Ozaukee County Medical Society held at the Smith Brothers Restaurant in Port Washington on March 23. Doctor Grossmann discussed "Cardiac Angiography and Catheterization." At the business session it was decided to institute a diabetes detection program.

Winnebago

Dr. Armin R. Baier, a member of the staff of the Milwaukee County Hospital, spoke before a meeting of the Winnebago County Medical Society at the Hotel Menasha, Menasha, on April 6. Doctor Baier discussed "The Artificial Kidney and Its Practical Use."

Ninth Councilor District

The spring meeting of the Ninth Councilor District Society was held on May 2 at the Hotel Whiting in Stevens Point. Following a dinner, *Dr. D. Murray Angevine*, professor of pathology at the University of Wisconsin Medical School, presented a paper on "So-called Collagen Disease." *Dr. W. C. Sheehan*, Stevens Point, discussed arthritis.

Wisconsin Surgical Society

Holding their semi-annual meeting in Madison on April 29, members of the Wisconsin Surgical Society participated in a clinical program and heard a number of scientific papers presented by members of that

point of departure for special feeding cases...

Dryco is not only the point of departure for almost every type of infant formula—it is also in itself a valuable food for special cases. Dryco assures ample protein intake while its low fat ratio and moderate carbohydrate content minimize digestive disturbances.

The applicability of the Dryco formula is strikingly seen in an observation by Pitt: "The majority of cases of infant diarrhea, seen in private practice, are of such nature that changing the formula to one of low fat and low carbohydrate is all that is necessary to correct the condition..." Dryco is specifically recommended for use in these cases.*

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Available at pharmacies in 1 and 2½ lb. cans.

*Pitt, C.K.: The Art and Science of Artificial Infant Feeding, J.M. Asso. Ala. 19:101 (Oct.) 1949.

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organization. From 8 to 10 o'clock in the morning they attended operative clinics at the State of Wisconsin General Hospital, following which a program on surgery of the chest was given. *Dr. William P. Young* discussed "Cystic Disease of the Lung"; *Dr. John T. Mendenhall* talked on "The Surgical Treatment of Pulmonary Abscess"; *Dr. Anthony R. Curreri* spoke on Mediastinal Tumors"; and *Dr. Joseph W. Gale* discussed "Carcinoma of the Lung." After a luncheon at the Wisconsin General Hospital, the scientific program resumed in the auditorium of the Service Memorial Institutes Building, with *Dr. Carl W. Eberbach*, Milwaukee, presiding. *Dr. Frederick Bunkfeldt, Jr.*, Milwaukee, presented a paper on "Repair of Extensor Injuries of the Forearm"; *Dr. Nathan E. Bear*, Monroe, discussed "Colles' Fractures"; *Dr. Paul F. Doege*, Marshfield, spoke on the "Renewed Hope of the Cure of Carcinoma of the Cervix"; *Dr. Samuel B. Harper*, Madison, discussed "Vaginal Hysterectomy"; and *Drs. Thomas J. Snodgrass*, Janesville, *Wayne A. Munn*, also of Janesville, and *Thomas H. Flarity*, Beloit, presented a survey of "Gallbladder Surgery: A Study of the Results of Surgical Treatment in Rock County." Following a business meeting, a dinner was served at the Maple Bluff Country Club, where *Dr. Warner S. Bump* of Rhinelander delivered his presidential address.

American Academy of General Practice

Manitowoc County Chapter

Dr. E. C. Cary, Reedsville; *Dr. Charles Wall*, Manitowoc; and *Dr. Wallace Marshall*, Two Rivers, were elected president, vice-president, and secretary respectively of the newly organized Manitowoc County chapter of the American Academy of General Practice. There were eighteen charter members. The charter was presented to the group by *Dr. George E. Forkin*, Menasha, president of the Wisconsin chapter, at a dinner held at the Hotel Manitowoc in Manitowoc on April 20. Other guests at the dinner included *Drs. W. B. Hildebrand*, Menasha, secretary of the Wisconsin chapter of the Academy, who led the discussion following the address of State President Elect *E. L. Bernhart* of Milwaukee. Doctor Bernhart described the objectives of the organization. Other guests were *Drs. J. P. Canavan*, Neenah, first president of the state chapter and *Oscar Foseid*, Menasha, a member of the board of directors, and Mr. Al Luthmers, secretary of Milwaukee Surgical Care.

Outagamie County Chapter

Dr. George Boyd of Kaukauna was named president of the Outagamie County chapter of the American Academy of General Practice at an organizational meeting in April. *Dr. F. J. Rankin* of Appleton was elected secretary. About twenty-five doctors from Outagamie County attended, and it is hoped that eventually the organization may be extended to include physicians from the entire Fox River Valley. *Dr. Donald C. Ausman*, Milwaukee, secretary of the Milwaukee chapter, discussed the work of the state organization and the committee on postgraduate education, of which he is chairman. *Drs. George E. Forkin* and *W. B. Hildebrand*, both of Menasha, president and secretary respectively of the Wisconsin chapter, also assisted in organizing the chapter.

NOTES ON CLINICAL PATHOLOGY

(Continued from page 403)

6. *X-ray Studies.*—Densities may be seen in the region of the pancreas indicating the presence of pancreatic calculi. X-ray studies are also important in the study of celiac disease, in the demonstration of various gastroenteric fistulae, in certain biliary tract conditions, in regional enteritis, and in some cases of pancreatic and intestinal neoplasms.

7. *Miscellaneous Studies.*—The following table is given to briefly summarize a variety of laboratory findings which may be useful in differential study:

	Pancreatic Steatorrhea (Retarded Digestion)	Intestinal Steatorrhea (Retarded Absorption)
Fasting blood sugar values	May be elevated	Usually low
Urine sugar determinations	May be positive	Negative
Glucose tolerance curve	May be diabetic	Usually flat with oral and normal with intravenous method
Blood calcium	May be low	May be especially low in sprue. Tetany occasionally seen
Plasma proteins	Commonly normal	Often low
Serum amylase	May be elevated early in acute pancreatitis	Normal
Serum lipase	May be elevated	Normal
Anemia	Variable	Frequent (May be macrocytic in sprue)
Urine and stool urobilinogen	Normal	Very low in biliary obstruction
Blood bilirubin (van den Bergh)	Normal	Increased direct and total in biliary obstruction
Vitamin deficiencies	Usually absent	Common
Studies for protoza and significant enteric organisms	Usually negative	May be positive

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2. Ayers, W. B., Stowens, D., and Ochsner, A.: Fibrocystic disease of the pancreas, J. A. M. A. 142: 7–12 (Jan. 7) 1950.
3. West, C. D., Wilson, J. L., and Eyles, R.: Blood amino nitrogen levels following injection of proteins and of a protein hydrolysate in infants with normal and with deficient pancreatic function, Am. J. Dis. Child. 72:251 (Sept.) 1946.
4. Anfanger, H., and Heavenrich, R.: Amino acid tolerance tests in infants, Am. J. Dis. Child. 77:425–436 (April) 1949.
5. Ricketts, H. T., Maimon, S. N., and Knowlton, K.: Steatorrhea, Med. Clin. North America, W. B. Saunders Co., (Jan.) 1947, page 125.

—W. H. Jaeschke

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Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.

News Items and Personals

Dr. Anton Schramel Appointed District Health Officer

Dr. Anton J. Schramel, deputy commissioner of health for the city of Milwaukee for the past four years, was appointed a district health officer by the State Board of Health at a meeting in Madison on April 7. Doctor Schramel's appointment became effective April 17 for District 3, which includes Calumet, Dodge, Fond du Lac, Manitowoc, Ozaukee, Sheboygan, Washington, and Winnebago counties. Headquarters for the district are in Fond du Lac. During World War II the doctor served as a major in the Army Medical Corps. Following his graduation from Marquette University School of Medicine in 1933 he was in general practice for six years.

Jubilee Celebration Held for Abrams Physician

Fifty years of medical service was commemorated in the village of Abrams on March 19, when the citizens held a jubilee celebration to honor Dr. R. C. Faulds, practitioner in that community since 1900.

Doctor Faulds, a member of the Fifty Year Club of the State Medical Society, graduated from the Wisconsin College of Physicians and Surgeons, now Marquette University School of Medicine, in 1898. Following a brief practice in Suring, he moved to Abrams in 1900.

Dr. Stephan Epstein Heads Hospital Staff

STEPHAN EPSTEIN

Dr. Stephan Epstein was named chief of staff of St. Joseph's Hospital, Marshfield, at a staff meeting held in April. Doctor Epstein succeeds *Dr. E. J. McGinn. Dr. J. M. Wickham* was elected vice chief of staff and *Dr. John B. Miale,* secretary. The election was preceded by a dinner in the dining room of the hospital.

Dr. O. H. Epley Attends Convention of Railway Surgeons

Dr. O. Hoyt Epley, New Richmond physician, attended the sixty-second annual convention of the American Association of Railway Surgeons, held at the Drake Hotel, Chicago, April 4–5. Doctor Epley has been the local surgeon in New Richmond for the Chicago and Northwestern Railroad since 1907. In addition to his private practice, he is a visiting physician for the St. Croix County Hospital and is chief of staff for the Holy Family Hospital in New Richmond.

Dr. A. J. Klein Addresses Pharmacists Meeting

Dr. A. J. Klein of Eau Claire was a guest speaker at a meeting of the Chippewa Valley Pharmacists held at Hotel Eau Claire in Eau Claire on April 12. He presented a paper on "Treatment of Peptic Ulcer," discussing the incidence, pathogenesis, and treatment of the disease.

Oconto Physician Addresses Women's Group

F. E. ZANTOW

Dr. Forrest Zantow of Oconto was the guest speaker at a meeting of the Oconto Woman's Club held at the Presbyterian Church club rooms in that community on April 3. Doctor Zantow spoke on new drugs recently perfected for medical care.

Madison Psychiatrist Addresses Meeting at Wausau

A luncheon, sponsored by the Marathon County Mental Health Committee, was held at the Wausau Club, Wausau, on April 17 for ministers, priests, and rabbis attending the pastoral counseling institute in that city and for members of the Marathon County Medical Society. Guest speakers were Drs. Harold F. Borenz, Madison psychiatrist, and Carrol A. Wise, Evanston, Ill., psychologist. Doctor Borenz is a member of the staff of Mendota State Hospital.

Dr. Elizabeth Baldwin Named Head of Professional Group

Dr. Elizabeth Baldwin of Marshfield was named president of the Marshfield Business and Professional Women's Club at a meeting in the dining room of St. Joseph's Hospital on April 17. The group holds membership in the Wisconsin Mental Health Association and has contributed furnishings to the pediatrics ward of St. Joseph's Hospital.

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(See Archives of Dermatology and Syphilology, May, 1950, for Scientific Program)

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AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. W. S. Middleton Receives Double Honor

W. S. MIDDLETON

Dr. William S. Middleton, dean of the University of Wisconsin Medical School since 1935, was notified recently that he was one of two Americans chosen to receive an honorary degree at Cambridge University, Cambridge, England, in June. The degree of doctor of science will be conferred upon Dean Middleton and Dr. Vannevar Bush, president of the Carnegie Institute in Washington, D. C. The news of this honor was announced on April 20, while Doctor Middleton was in Boston, being installed as president of the American College of Physicians.

A graduate of the University of Pennsylvania School of Medicine, the doctor joined the staff at the University of Wisconsin Medical School in 1912. During World War II he served in England as chief consultant in medicine in the United States Army Medical Corps. He was awarded, in addition to honors conferred by the United States, the Order of the British Empire and the Croix-de-Guerre of France.

Mendota State Hospital Names Two Staff Members

Dr. Edward M. Burns, assistant professor of neuropsychiatry at the University of Wisconsin Medical School, on April 13 was named clinical director in charge of medical and psychiatric services at Mendota State Hospital. Dr. Norman O. Evenson, formerly senior physician and surgeon at Stockton State Hospital, Stockton, Calif., will serve as psychiatrist.

Doctor Burns has been on the faculty at the University of Wisconsin since 1947. A diplomate of the American Board of Psychiatry and Neurology, he served as a neuropsychiatrist in the United States Navy for four and one-half years during World War II.

Doctor Evenson, a graduate of the University of Colorado Medical School, was chief psychiatrist at the United States Marine Corps base at San Diego, Calif., during World War II.

Dr. Rolf Poser Joins American College of Physicians

Among physicians becoming members of the American College of Physicians in Boston, April 17–22, was *Dr. Rolf Poser*, Columbus. Doctor Poser, a graduate of the University of Wisconsin Medical School, is a diplomate of the American Board of Internal Medicine.

Neuropsychiatrist Addresses Dieticians

Guest speaker at the annual dinner of the Wisconsin Dietetic Association held in Madison on March 24 was *Dr. Annette Washburne*, professor of neuropsychiatry and preventive medicine at the University of Wisconsin Medical School. The Association held its convention in the Memorial Union on the University of Wisconsin campus on March 24 and 25.

Dr. A. S. Jackson Honored at Western Medical Meeting

Colorado and Wyoming members of the International College of Surgeons honored *Dr. Arnold S. Jackson*, Madison physician, at their annual meeting held in Denver on April 22. Doctor Jackson presented the main address at the session, discussing "Development in the Treatment of Hyperthyroidism." His talk was illustrated with slides.

Madison Physician Speaks to Sauk County Groups

"Emotional Disturbances in Children" was the subject of a talk by *Dr. H. Kent Tenney*, Madison pediatrician, at a joint meeting of the Parent–Teacher Association and Medical Auxiliary in Sauk County on April 18. The meeting was held in Baraboo. Doctor Tenney pointed out that the large majority of the troubles of adult patients consulting psychiatrists had their origin in childhood disturbances and that children should feel parental approval and security in their home life.

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Minnesota Physician Speaks at University Meeting

Dr. Ruth E. Boynton, director of student health service at the University of Minnesota, was a guest lecturer at the University of Wisconsin Medical School on April 21. The address, presented in conjunction with the University of Wisconsin Medical Society, was entitled "The Development and Philosophy of Student Health Services."

Dr. C. M. Kurtz Speaks at Oshkosh Meeting

Dr. Chester M. Kurtz, professor of medicine at the University of Wisconsin Medical School, was the principal speaker at a meeting of the Rotary Club of Oshkosh held at the Hotel Athearn in that city on April 17. He presented an illustrated lecture on "Rheumatic Fever."

SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

Meeting at the Raulf Hotel in Portage on April 11, members of the Columbia–Marquette–Adams County Medical Society heard a talk by *Dr. W. D. Stovall*, Madison, director of the State Laboratory of Hygiene. The doctor, who is also a past president of the State Medical Society, discussed the "Relationship of the American Medical Association to the General Practitioner." Members of the Sauk County Medical Society and their wives were guests at the meeting.

Dane

Members of the Dane County Medical Society were guests of the Dane County Veterinary Association at a dinner meeting at the Park Hotel, Madison, on April 6. Guest speaker was Dr. N. B. McCullough of the University of Chicago School of Medicine, who discussed "Human Brucellosis," with emphasis on diagnosis and treatment.

Green

H. M. SUCKLE

Dr. Henry M. Suckle, Madison neurologist, was the principal speaker at a meeting of the Green County Medical Society on April 11 at the Swiss Wheel in Monroe. Doctor Suckle spoke on head injuries.

Rock

The Hotel Hilton in Beloit was the meeting place of the Rock County Medical Society on March 28. Dr. M. H. Stauffer of the Mayo Clinic, Rochester, Minn., addressed the group on "Recent Advances in the Diagnosis of Gastrointestinal Diseases."

TWELFTH DISTRICT NEWS

Milwaukee Physician Speaks to Dentists at Convention

Dr. Maurice Hardgrove, Milwaukee physician, was one of the featured speakers at the annual meeting of the Wisconsin State Dental Society held in Milwaukee during April. In a talk entitled "How to be a Dentist and Live Long," Doctor Hardgrove pointed out that professional men should plan vacations and rest periods in their program to avoid mental and nervous strain.

Danish Doctor Addresses Hospital Staff

Dr. Sven Kiaer, orthopedic physician from Copenhagen, Denmark, spoke before the medical staff of the Veterans Administration Hospital, Wood, on April 17. His subject was "Some Causes of Hip Pain."

SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

The Arthur W. Rogers Memorial Lecture, sponsored by the Rogers Memorial Sanitarium, Oconomowoc, was delivered before the Milwaukee Academy of Medicine meeting at the University Club of Milwaukee on April 18. The lecture, entitled "The Adaptation Syndrome and Diseases of Adaptation," was given by Dr. Hans Selye, professor and director of the Institute of Experimental Medicine and Surgery at the University of Montreal, Montreal, Canada. That morning Doctor Selye conducted a special clinic at the Veterans Administration Hospital, Wood.

Milwaukee Neuro-Psychiatric Society

Dr. G. R. Bell, medical director of the Shadow Brook Health Foundation at Willowdale, Ontario, Canada, addressed a meeting of the Milwaukee Neuro-Psychiatric Society at the University Club of Milwaukee on April 19. The doctor discussed "New Methods for Improving Insight and Motivation in the Treatment of Alcohol Addiction."

Milwaukee Oto-Ophthalmic Society

Meeting at the Milwaukee Athletic Club, members of the Milwaukee Oto-Ophthalmic Society heard a presentation by *Dr. I. I. Cowan* of Milwaukee on April 25. Doctor Cowan spoke on "Diagnosis and Therapy with Radioactive Isotopes."

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New Members

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P. V. Bergen, M.D., Beaver Dam.

D. G. MacMillan, M.D., 122½ North Main Street, Rice Lake.

Change of Address

D. E. W. Wenstrand, M.D., Milwaukee, to Box 1062 Tryon, North Carolina.

Isabelle Gadzikowski, M.D., West Virginia, to Sunshine Sanitorium, Grand Rapids, Michigan.

G. E. Bryant, M.D., Menomonie, to Maryland General Hospital, Baltimore, Maryland. (as of June 1, 1950)

R. T. Cunningham, M.D., Wood, to Veterans Administration, Fort Harrison, Montana.

William Merkow, M.D., Milwaukee, to Waukesha.

J. W. Frye, M.D., Milwaukee, to Veterans Hospital, Wood.

C. W. Stiehl, M.D., Milwaukee, to Algoma.

D. M. Pick, M.D., Two Rivers, to Manitowoc.

T. J. Pendergast, M.D., Milwaukee, to 2317 North 101st Street, Wauwatosa.

D. E. Matthiesen, M.D., Lancaster, to 3196 Carrington, Memphis, Tennessee.

MARRIAGES

Dr. A. M. Sonneland, Jr., and Miss Elizabeth Hayes Schneiders, Madison, on April 22.

Dr. John David Silbar and Dr. Muriel J. Cheplin, New York, on April 15.

DEATH

Dr. Frederick L. Grover, widely known Hartland physician, died suddenly while on a medical call near that community on April 1. A practitioner in Hartland for twenty years, the doctor was 51 years old.

Born in Milwaukee on December 24, 1898, Doctor Grover received his medical degree from Marquette University School of Medicine in 1924. Following internship at Milwaukee County Hospital, he entered practice in Milwaukee. In 1930 he moved to Hartland, where he served for a long period as village health officer. He was on the staff of the Waukesha Memorial Hospital.

A past president of the Waukesha County Medical Society and its secretary for the past five years, the doctor also held membership in the State Medical Society and the American Medical Association.

He is survived by his wife, two sons, and a daughter.

CORRESPONDENCE

Milwaukee, Wisconsin
April 14, 1950

Dear Sir:

The Industrial Health Clinic at Kohler Village yesterday was excellent and I wish to take this opportunity to tell you that it was most worthwhile. The Plant Tour was interesting, the informative lectures of the doctors were stimulating, and the gracious hospitality of the Kohler people was most enjoyable.

Since I am Chairman of the Milwaukee Industrial Nurses and will be sending a notice out shortly announcing our May meeting, I will include a note of reminder to them of the Globe–Union Health Clinic.

Thank you again for a most gratifying day.

Sincerely,
(s) Margaret M. Wiesner, R. N.
Industrial Nurse

Comment on Industrial Health Clinic, Wisconsin Rapids, April 20

Consolidated Water Power & Paper Co.
Wisconsin Rapids, Wisconsin

April 24, 1950

Dear Sir: It was a pleasure to work with your Association on this [clinic], and we have had many fine comments from the doctors who attended. They apparently enjoyed the fine program which you arranged.

It was our pleasure to be able to participate in a program like this, and we want to especially thank the Medical Association for allowing us to participate. We have been trying for a long time to get the local doctors to our plant individually, but they were always too busy. This clinic certainly accomplished much in that line and in our relations with the medical profession. Thank you very much.

Sincerely yours,
(s) George S. Nelson
Claims and Safety Manager

Sparta Clinic
Sparta, Wisconsin

April 27, 1950

Gentlemen: The [clinic] at Lake Delton was wonderful and I want to congratulate you on putting on such a fine meeting. I have heard many remarks from other men who appreciated it just as much as I did. The location for this meeting seemed to be perfect and could hardly be improved upon. All of the subjects presented were excellent and all of the men were unusually interesting. It seems to me that this is the type of meeting that rings the bell and I am in favor of meetings like this and not any longer than this one was. I think an all-day session many times is much too much for all of us to absorb and if the subjects are confined to the afternoon and evening that is quite sufficient.

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(s) D. C. Beebe, M. D.

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The Journal Bookshelf

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All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal* "Bookshelf," are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Clinical Case-Taking; History-Taking and Physical Examination or Semiology of Disease in the Various Systems. By George R. Herrmann, M. D., Ph.D., Professor of Medicine, University of Texas. Fourth edition. St. Louis, The C. V. Mosby Company, 1949. Price $3.50.

"Clinical Case-Taking" represents the effort of a master clinician to make available to the student and house officer the lessons of his own wealth of experience in the art of interviewing and examining patients. It is designed as a pocket-sized volume for use at the bedside and in the clinic and, in addition to detailed outlines for study of patients with different types of disease, contains, in an appendix form, a brief but valuable review of the differential diagnosis of some common symptoms. Perhaps the greatest value of the book lies in the introductory pages on the philosophy and technic of studying the patient rather than in the detailed outlines which follow. Its greatest drawback rests in the fact that, since it does not represent a complete textbook of physical diagnosis, it can be prescribed for student use only in conjunction with other texts and, hence, would add one more to the already large and expensive list of books which a medical student must buy. One might disagree somewhat with the method of presenting individual history outlines for diseases of various organ systems, both because this presupposes at least partial diagnosis on the student's part prior to the obtaining of a complete record and also because it might, to some extent, detract from interest in the organ systems not primarily under study. Properly employed, this should not be the case but such misdirection is apt to develop in spite of the greatest preceptorial efforts. Aside from this single difference in opinion, the book is recommended as a potentially very valuable teaching aid.—J. L. S.

Clinical Aspects and Treatment of Surgical Infections. By Frank Lamont Meleney, M.D., F.A.C.S., Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University; Associate Visiting Surgeon, Presbyterian Hospital, New York City. With a Foreword by Allen O. Whipple, M.D. Pp. 840, with 287 figures. Philadelphia and London, W. B. Saunders Company, 1949. Price $12.00.

This excellent and authoritive volume concerns the pathogenesis, bacteriology, symptoms, signs, and treatment of surgical infections. After an initial discussion on physiologic considerations in surgical infections by Dr. John S. Lockwood, the field of surgical infections is taken up by regions, systems, organs, and tissues. Chapters on surgical infections

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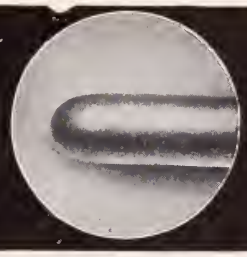

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of the peritoneum by Dr. H. D. Harvey, and surgical infections in war wounds by Dr. A. B. Longacre and Dr. W. R. Sandusky are included.

The book contains numerous excellent illustrations, and each chapter is followed by illustrative histories of cases which emphasize the signs, symptoms, or treatment. There is an extensive bibliography at the end of each chapter and a complete index at the end of the volume. The development and use of the various antibiotics, including penicillin, streptomycin, and bacitracin (developed by the author), are well presented, and at the same time the importance of general surgical principles is stressed. This book illustrates perhaps the optimum cooperation that can be obtained between the surgeon and the surgical bacteriologist. The chapters dealing with ulcerative colitis, gangrenous infections of the skin, and infections of the hand are especially good. The author is an authority on the undermining burrowing ulcer and progressive bacterial synergistic gangrene, so important in preantibiotic days. This book is not meant to be read at one sitting, but is an excellent textbook and reference book for student, intern, and surgeon alike.—J.T.M.

Modern Practice in Psychological Medicine, 1949. Edited by J. R. Rees, M.D., New York: Paul B. Hoeber, Inc., 1949. Price $10.00.

This is a textbook of psychiatry written as a symposium by a group of distinguished British physicians and teachers. It is intended for the student of medicine and general practitioner.

The book is organized on the broad base of the wide application of psychiatric principles to medicine, psychology, sociology, cultural anthropology, and education, and succeds in integrating psychiatry with the general practice of medicine. Beginning with chapters on general health, normal and abnormal emotional development, and personality types, it proceeds to discuss the neuroses, behavior disorders, psychoses, therapy, industrial relationships, medical and psychiatric social service work, and the medicolegal aspects of psychiatry. The material is presented in a concise, readily under-

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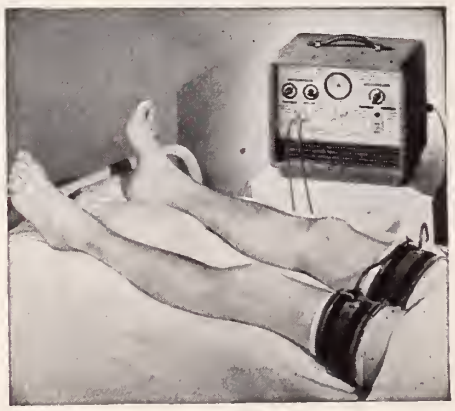

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"Modern Practice in Psychological Medicine" is an entirely new and refreshing consideration of the problems of psychiatric medicine. It is recommended especially to the general practitioner.—M.J.M.

Oral and Dental Diagnosis; With Suggestions for Treatment. By Kurt H. Thoma, D.M.D., F.D.S.R.C.S., Eng., Professor of Oral Surgery, Emeritus, and Brackett professor of Oral Pathology, Harvard University. With Contributions by Henry Goldman, D.M.D., Head of the Dental Department, Beth Israel Hospital, Boston; Fred Trevor, D.M.D., Formerly Instructor in Oral Pathology, Harvard Dental School. Third edition. Pp. 563, with 776 illustrations, 60 in color. Philadelphia and London, W. B. Saunders Company, 1949. Price $9.50.

K. H. Thoma's third edition of "Oral and Dental Diagnosis" is a revision of earlier editions. He has added more data on the accepted methods of treatment.

New developments in dentistry are discussed under headings: "Prophylactic Treatment with Flourides"; "Gingivectomy in Perodontal Disease"; and "Treatment of Fractures of Maxillae."

The book was originally written to serve as a text for dental schools, but practitioners, both medical and dental, will find this work very valuable for reference.—E.F.W.

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Average maintenance dose: 1 tablet daily.
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1. *Withering, W.:* An account of the Foxglove, London, 1785.
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FOR SALE: Ophthalmologist–otolaryngologist wishes to sell forty year old established practice located in an industrial area of Milwaukee. Doctor agrees to work with buyer until business is secure. Address replies to No. 283 in care of the Journal.

AVAILABLE: Radiologist, aged 31, Wisconsin license. Eligible for Boards in both diagnosis and therapy. Completing three-year training in large teaching institution. Available July 1, 1950. Address replies to No. 279 in care of the Journal.

FOR SALE: General electric portable shockproof x-ray unit in excellent condition at ⅓ of list price. One new mobile 30 MA, 96 PKV, Fischer shockproof x-ray unit at $795. One new Fischer short wave with hinged drum electrode and arm, FCC type approved, $355. One used Jones metabolism unit guaranteed accurate at one-half price. One new style Hyfrecator used only a few months, at marked reduction. One used direct writing electrocardiograph at about one-half price, factory reconditioned. C. C. Remington, 720 North Jefferson Street, Milwaukee 2. Telephones Daly 8-6368 and Woodruff 2-4028.

FOR SALE: Practice of deceased physician, including supplies and office furniture in village of 1,000 in center of rich agricultural district. Address replies to No. 285 in care of the Journal.

PHYSICIAN AVAILABLE: Desire to associate with doctor or clinic in Milwaukee for evening office work. Trained in internal medicine. Call Dr. J. E. Gruender, Hilltop 5-6089.

WANTED: Physician as associate with two other doctors in city of about 5,000 in east central Wisconsin. Fine hospital. Excellent opportunity. Address replies to No. 287 in care of the Journal.

FOR SALE: Practice in Central Wisconsin city of 30,000, with equipment, including Hamilton Nu-Tone examining table, Pelton autoclave, x-ray with buckey, Birtcher cautery, diathermy, other essential instruments, and Duran office furniture. Ideal for young man who wishes to begin profitable independent practice. Availiable September 1. Reason for selling: specializing. Address replies to No. 305 in care of the Journal.

LOCATION WANTED: Young physician, 25, married, licensed in Wisconsin, recently completed internship, seeking location for general practice in smaller Wisconsin community, or position as assistant to busy general practitioner. Address replies to No. 302 in care of the Journal.

WANTED: Qualified public health nurse as county nurse in beautiful southwestern Wisconsin. Generalized service in rural area. Beginning salary, $3,000, plus mileage; vacation and sick leave with pay. Must have own car. Write County Health Department, Court House, Richland Center, Wisconsin.

AVAILABLE IMMEDIATELY: Large general practice in town of 1,300 about 15 miles from Green Bay. Office includes large waiting room, two examining rooms, drug room and laboratory and small room for files, etc. Also x-ray machine and large stock of drugs. Hospital facilities and staff connections available. Practice should gross $16,000 first year. Also, a four bedroom house for immediate occupancy. Address replies to No. 298 in care of the Journal.

WANTED: Young physician for general practice in small Scandinavian community in Wisconsin, to associate with progressive clinic group. Excellent hospital facilities. Partnership arrangement. Address replies to No. 291 in care of the Journal.

WANTED TO BUY: Tilt table for proctoscopic examinations. John A. Tasche, M. D., 809 North Eighth Street, Sheboygan, Wisconsin.

FOR SALE: GE model B electrocardiograph, photographic unit. Operates perfectly. Price $85. Address replies to H. W. Kishpaugh, M. D., 318 Strong Building, Beloit, Wisconsin.

WANTED: General practitioner for association with long established physician and surgeon, F. A. C. S., in suburban town of Twin Cities. Good hospital facilities. Salary and percentage. Excellent opportunity. Appointment available. Minnesota license or National Board necessary. Address replies to No. 303 in care of the Journal.

WANTED: Locum tenens for the month of August, living quarters and office furnished. Address replies to No. 304 in care of the Journal.

AVAILABLE: Excellent opening for a young doctor in prosperous community in Northwestern Wisconsin, to succeed an 81 year old doctor who has practiced medicine in this community for over 50 years and now desires to retire. Excellent hospital facilities only 6½ miles distance, on a paved highway. Office and living quarters available. Address replies to No. 306 in care of the Journal.

EENT ASSOCIATE WANTED: by Board internist and general surgeon. Small clinic, southern Wisconsin, well located in good industrial, farm, and resort area. Salary guarantee plus percentage, leading to partnership. Address replies to No. 307 in care of the Journal.

AVAILABLE: Surgeon, age 32, married, desires assistantship or association with general surgeon certified by or acceptable to the Board for further training. Completing 3 year approved surgical residency and one year basic sciences in June. Licensed in Wisconsin. Address replies to No. 308 in care of the Journal.

FOR SALE: General practice. Owner retiring after 39 years in the same location in northeast Wisconsin community of 3,500. Home, office, and equipment for sale. Good location, good schools and churches. Can easily be made a partnership. Address replies to No. 290 in care of the Journal.

WANTED: Young practitioner interested in obstetrics. Excellent opportunity. Housing available. Address replies to No. 296 in care of the Journal.

WANTED: A position with a group or clinic by a Board-eligible surgeon, age 31, available in August 1950. Address replies to No. 301 in care of the Journal.

WANTED: EENT man or ophthalmologist capable of doing refractions for association in clinic in busy Wisconsin area. Address replies to No. 300 in care of the Journal.

FOR SALE: Country practice in northwest Wisconsin. No competition. Modern residence, ideally located. Annual dairy income in territory. Nothing to buy but five bed room residence, with office room, waiting room, and laboratory in residence. Separate parking and sidewalk to walting room. Spacious lawn, foliage, and ideal residence. Young man can use extra rooms for hospital rooms. Selling reason: coronary thrombosis. Address replies to No. 170 in care of the Journal.

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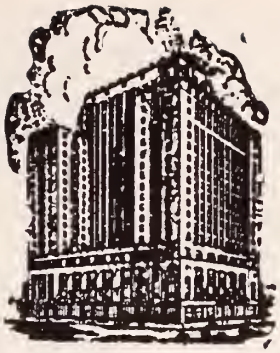

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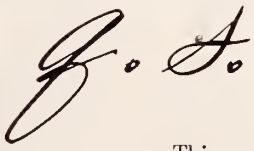

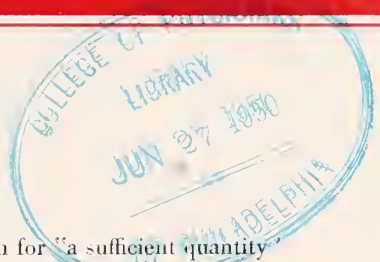

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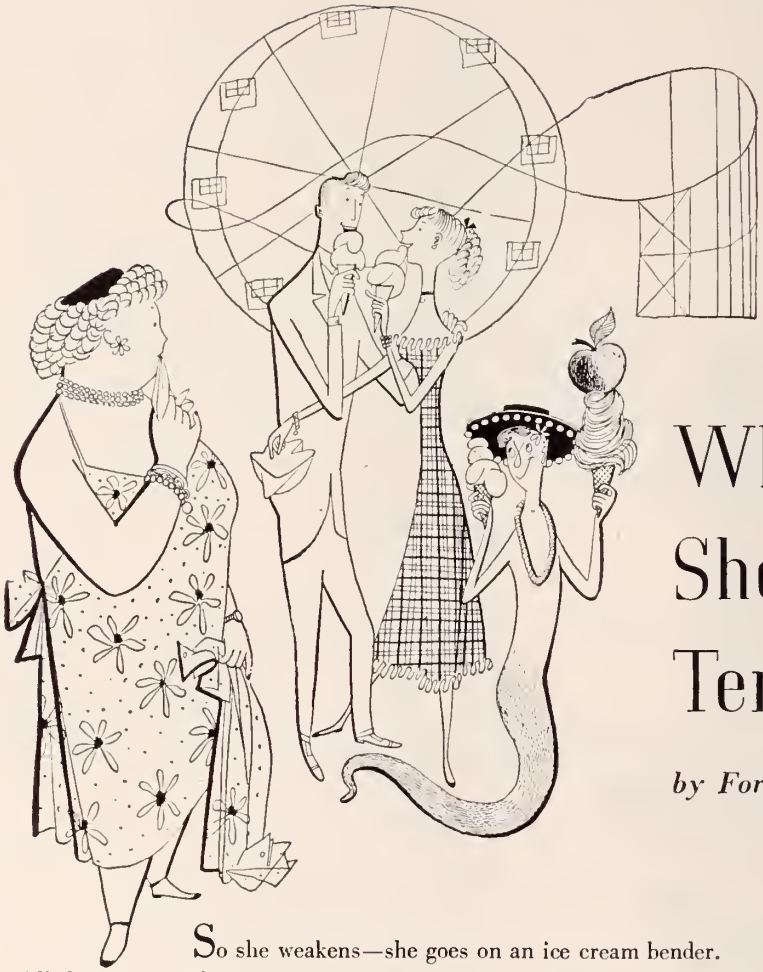

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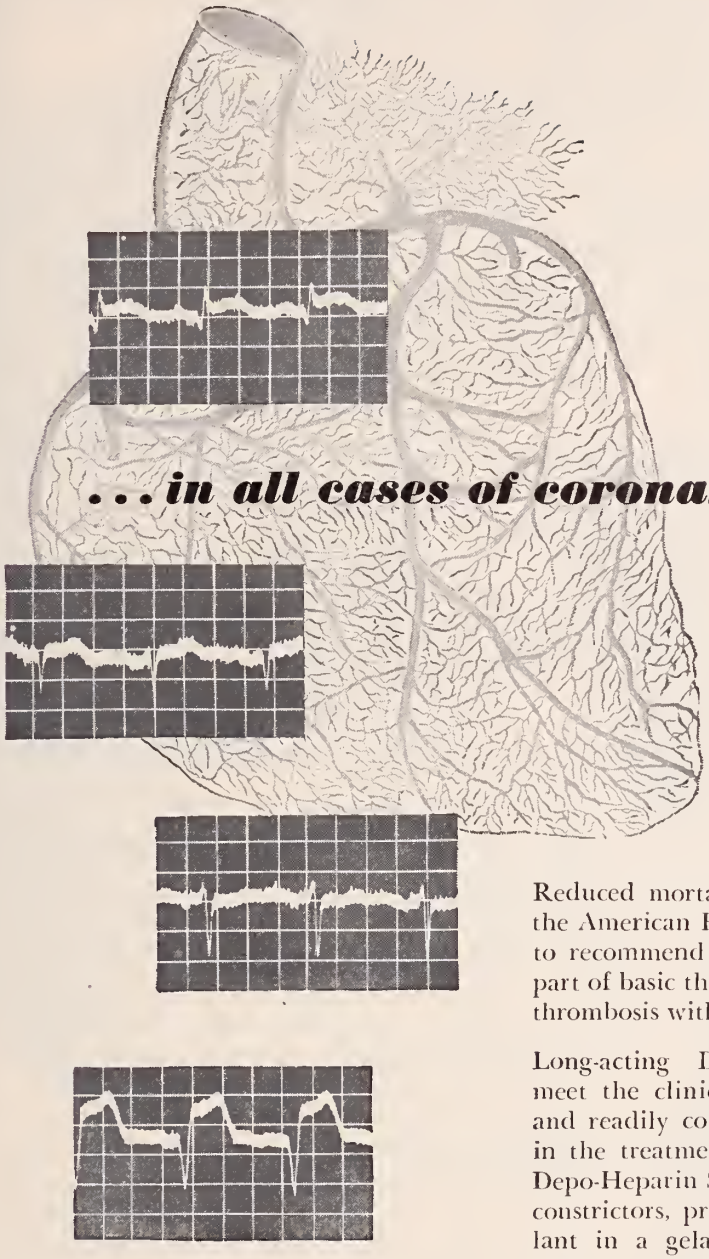

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1. Wright, et al: Am. Heart J. 36, 801 (Dec.) 1948.

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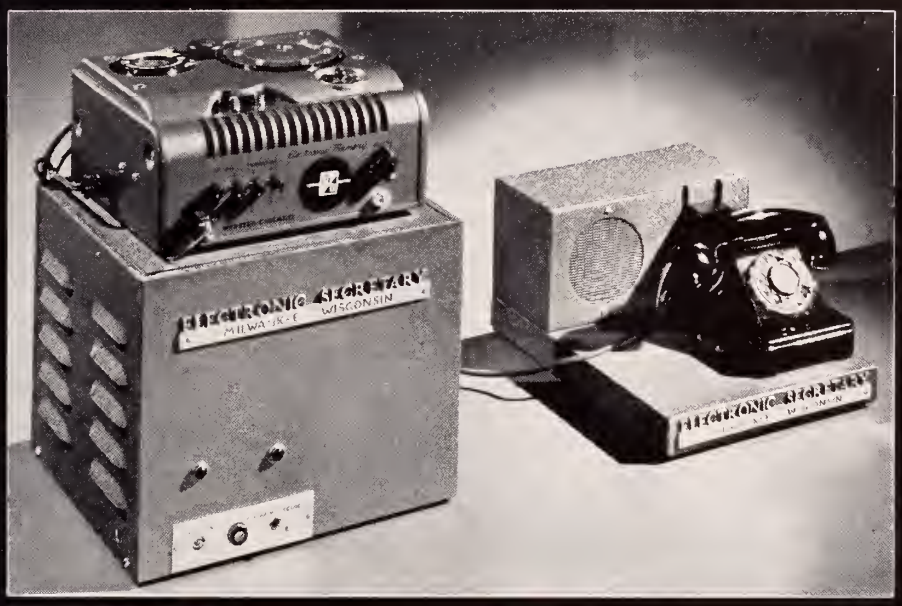

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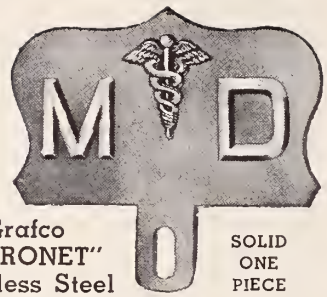

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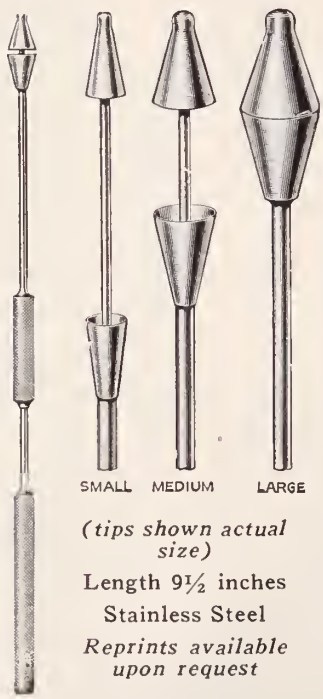

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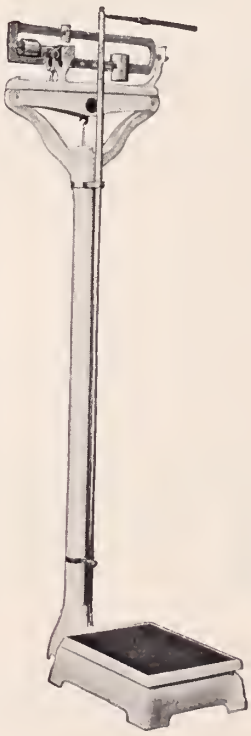

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Sanatorium Consultation

The State Board of Health first offered the services of a committee of consultants to the tuberculosis institutions of the state in 1942. This committee, consisting of four members specializing in chest diseases, visited each sanatorium annually for three years. It was agreed at the end of that time that the services of the committee had been of considerable value but that certain changes in the organization of the consultation service should be made in order to make it entirely satisfactory. On a number of occasions during its rounds the consultation committee had the pleasure of entertaining visiting physicians from other states who were interested in observing this method of consultation. As a result, Minnesota now has a somewhat similar service which was modeled after that of Wisconsin.

In the interval between 1946 and 1949 the Wisconsin State Board of Health and a majority of the sanatorium medical directors were anxious to have the consultation service resumed, but the necessary changes in organization had not been worked out to the satisfaction of all concerned. About a year ago the Committee on Tuberculosis and Chest Diseases of the State Medical Society suggested a plan of operation which was accepted by the Board of Health in all its essential details.

Sanatorium consultation under this new plan was resumed early this year. A panel of seven consultants, consisting of four specialists in medical chest diseases and three thoracic surgeons, was designated by the Board of Health. The medical director of the sanatorium to be visited chooses one internist and one surgeon from the panel; the director of the Division of Tuberculosis of the State Board of Health constitutes the third member of the consultation committee which is to visit each institution annually.

When the consultation committee visits a sanatorium, the roentgenograms of all resident patients in the sanatorium are presented together with a summary of the history, physical examination, and significant laboratory findings. Not only is each case reviewed, but general therapeutic problems are discussed as they arise. The consultants are in a position to compare the diagnostic and therapeutic procedures in the various sanatoria. Sometimes a medical director can be advised that a procedure which

he had not realized was feasible for his institution had been simplified and used successfully in another institution.

The matter of reports of the consultants on their visits has not as yet been fully clarified and, as yet, no formal reports have been made. The consultants believe that their primary purpose in visiting an institution is to render a medical consultation service. It is possible that reports of the consultants, submitted to the sanatorium trustees as well as to the medical director, might be of value in emphasizing the need for additional equipment or personnel in an institution.

The attendance of all physicians with an interest in chest diseases in the community served by the sanatorium is encouraged at the consultation sessions. Medical directors of nearby sanatoria are also afforded an opportunity of establishing a closer relationship with their neighbors and of comparing therapeutic methods.

At a meeting of the Committee on Tuberculosis and Chest Diseases this year it was suggested that visits of the consultants could afford an excellent opportunity for resident physicians of the larger institutions in the state to visit the smaller institutions so that they might obtain some insight into the problems existing in the treatment of patients in smaller communities. It was also suggested that the consultation service of the State Board of Health be closely coordinated with the consultation service being rendered to some sanatoria by the Wisconsin Anti-Tuberculosis Association.—JOHN D. STEELE, M. D.

Revolution or Evolution

Administrators and medical practitioners must disagree. They have no common ground upon which to meet. The administrator is trying to make ends meet. He is working with a fixed capital, and expenditures cannot exceed that capital. At least up to the present this has been true. The federal government officials, however, seem to think that deficit spending is a new technic for scientific living. Most of us, however, do not agree that this latest political discovery is either scientific or sound but feel rather that sometime the stability of currency will be proved to be essential to sound economy and sound economy a prerequisite to social progress.

However that may be, the administrator of public or private affairs is held to a budget. He is not permitted to follow the example of the chief executive of the national government and the members of the Congress. He must operate his division within the limit of his budget. His office associates and administrative assistants are tough on that point. Advancement in office and success in business are based upon the adoption and smooth execution of principles of good accounting and balanced budgets. Administrators must cut the corners, regardless of the need of the patient.

The doctor has a different objective, the objective of keeping his patient alive and restoring him to a functionally healthy individual. Costs cannot be considered too strictly in this project. The services required in diagnostic procedures, special drugs, or surgical operations may run individual costs into more expenditure of money than the administrator can afford and stay within the bounds of what the books show to be good administrative practice. When this conflict arises, the patient suffers the consequences of inadequate medical care. This is the breaking point between business management and good medical care.

The technical training and responsibilities of the administrator and the doctor are worlds apart. Here is the reason for the diametrically different opinions between some of those who propose and propagandize for compulsory sickness insurance and those who oppose and resist it. It is not possible to legislate adequate medical care, because legislation does not insure good practice. The administration of laws, the operation of private business, and the practice of medicine are ostensibly aimed at one purpose, public welfare; but the practitioners in these different endeavors arrive at their objective by the application of different kinds of disciplines, the reconciliation of which is cumbersome, time consuming and at times conflicting.

The doctor is trained for a highly specialized field of practice which requires the melding of many branches of science and other methods of observation in the use of which he loses sight of balance sheets, lines of operation, rules of management and regulatory directions which are essential to administrative practices.

The sick person does not fit into a pattern of applied science. Each one is different, and the technics used are different in each case. It is this compounding of scientific technics with experience and simple methods of observation that defies the organizational success and mass production technics of modern industry and commerce and the mass application of directives, rules and regulations of legislative administration. It is because each sick man presents a different problem from every other sick man that makes good medical practice the highly individual problem that it is. And, it is this individuality of disease and treatment in each sick man that defeats medical care by legislation and the regulatory management necessary for its administration.

Also, medical care and the prevention and control of disease are not exact and identical problems. The technics applied for the former are not the same as for the latter. To speak of health and the treatment and the care of the sick as one and the

same problem has become familiar these days. Perhaps this is based on the success of applied biologic science to community health problems during the early years of this century. Even he who runs can see that the application of these technics to community hygiene and sanitation has wrought improvement in the health and living conditions of people everywhere. And, it is these successes together with the tremendous popularity of science among the general public which has prompted the assumption that the treatment of the sick person, which is such a highly individual problem, may be attacked by the same methods.

No one thinks that medical care can not be improved. It has improved remarkably over the last ten years. Methods of medical practice and the care of sick people have never been static. It is philosophy of medical care by compulsion, operated by administrative technics, that is so alarming. In this connection, Dr. Haven Emerson, eminent public health physician, in his recent book, "Selected Papers," commenting on this subject, used a quotation from the biologist E. G. Conklin which is such a succinct statement that it bears repetition here. He said: "This shattering of things to bits in order to remould them nearer to the heart's desire is the method of revolution rather than that of evolution, of tyranny and compulsion rather than freedom and education, of autocracy rather than democracy. Nowhere in the living world is progress brought about by shattering things to bits, but rather by relatively minor changes in organization—truth cannot be established by compulsion, nor error permanently overcome by force."

AMERICAN COLLEGE OF SURGEONS TO MEET IN BOSTON

The thirty-sixth clinical congress of the American College of Surgeons will be held in Boston, October 23–27, with headquarters at the Hotel Statler and Copley Plaza.

Color television of surgical procedures from Massachusetts General Hospital to an auditorium in Mechanics Hall is one of the features of the meeting, and twenty-four hospitals in Boston and vicinity will hold operative clinics for visiting surgeons. Official meetings, scientific sessions, medical motion pictures, a technical exhibit, and the twenty-ninth annual hospital standardization conference are among the other features of the program. At the presidential meeting on Monday evening, October 23, Dr. Henry W. Cave of New York will be installed as president.

The College, founded in 1913, now has a total fellowship of 15,500. Several hundred new fellows will be admitted at the 1950 convocation on the evening of October 27 at the clinical congress.

BALTIMORE PSYCHIATRIST TO SPEAK AT MADISON

Dr. H. Whitman Newell, Baltimore, will deliver an address at the Service Memorial Institutes Building, Madison, on August 1, at a meeting to be sponsored by the State Mental Health Authority, University of Wisconsin Medical School, and Dane County Medical Society. His topic will be "Principles in Practices Used in Child Psychiatric Clinics." Doctor Newell, president of the American Orthopsychiatric Association and of the Baltimore Psychoanalytic Society, is an associate professor of psychiatry at the University of Maryland School of Medicine and directs the mental hygiene clinic of that institution.

All physicians and students are invited to attend this presentation at 8 o'clock in the evening.

The Diagnosis and Treatment of Chronic Occlusive Disease of the Peripheral Arteries*

By NELSON W. BARKER, M. D.
Rochester, Minn.

N. W. BARKER

Doctor Barker, head of a section in the division of medicine at the Mayo Clinic, received his medical degree from Rush Medical College in 1925. A diplomate of the American Board of Internal Medicine, he is a professor of medicine at the Mayo Foundation Graduate School of the University of Minnesota.

THE diagnosis of chronic occlusive disease of the peripheral arteries depends, first, on a high level of suspicion and, second, on a relatively simple examination which can be conducted by any physician without the use of complicated apparatus. Symptoms which should arouse suspicion are any pain, numbness, or abnormal sensation of cold in the extremities and especially intermittent claudication. The last is a pain, ache, or abnormal fatigue in the arch, calf, thigh, or hip which is induced only by effort or use of muscles and which subsides promptly on rest without change of position. Pain in isolated digits of any extremity occurring particularly at night and associated with a sensation of numbness also is a suggestive symptom.

Objective findings which should arouse suspicion are ulceration, gangrene, abnormal coldness, or discoloration, such as pallor, rubor, or cyanosis. The temperature and color changes are of even greater significance if confined to isolated digits or one extremity, since the involvement of arteries of extremities by occlusive disease is almost always asymmetric at any stage of its development. The presence of superficial thrombophlebitis also should suggest that occlusive arterial disease may be present.

The diagnosis of chronic occlusive arterial disease of the extremities can be established in almost all cases by the finding of definitely impaired or absent pulsations in one or more of the following arteries: brachial, antecubital, radial at the wrist, femoral in Scarpa's triangle, popliteal, and posterior tibial below and behind the internal malleolus. Because of anomalies, impairment or absence of pulsations in one or both ulnar or dorsalis pedis arteries alone is not necessarily of diagnostic significance. It requires only a little practice for any physician to acquire the ability to feel pulsations in the above-mentioned arteries and to have confidence in his ability to state whether they are present and normal, absent, or of definitely reduced volume. Occasionally palpation may be difficult in an obese or edematous extremity. The use of the oscillometer to detect impaired arterial pulsations may be of some value, but it is not a precision instrument and is unnecessary to a physician who has learned to palpate pulsations with his finger tips.

Another simple test for the presence of occlusive arterial disease is the test for postural color changes. The patient should be in a relatively warm room. The extremities are elevated for one minute. Abnormal pallor of digits, feet, or hands, and more particularly of isolated digits or one foot or hand as compared with its companion, is almost certainly diagnostic. If the extremities are then placed in the dependent position, the time which elapses before color returns and superficial veins fill is a rough measure of the degree of arterial insufficiency. A time lapse of fifteen to thirty seconds indicates moderate insufficiency and a lapse of more than a minute indicates severe ischemia. In many cases the return of color to an ischemic extremity is followed by excessive rubor for a few minutes. A positive result of the elevation-dependency test can be considered certain evidence of occlusive arterial disease even if it is noted in only one digit, but a negative result does not exclude occlusive arterial disease.

Rarely occlusive arterial disease may be confined to the digits or foot and thus not impair or obliterate pulsation in major arteries. In such cases it is usually detectable by the elevation-dependency test or by the presence of gangrene or necrotic ulceration of digits which cannot be explained as the result solely of local infection or severe mechanical or thermal trauma.

For practical purposes measurements of skin temperature by instruments, plethysmography, and arteriography are not necessary for the diagnosis of chronic occlusive peripheral arterial disease. Their chief value is in research, appraisal of therapeutic procedures, estimation of degrees of associated arterial spasm, or determination of exact location of arterial lesions when the diagnosis has been made.

Approximately 90 per cent of cases of chronic occlusive disease of the peripheral arteries seen in clinical practice result from either thromboangiitis

* Read before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

obliterans (Buerger's disease), an inflammatory and proliferative lesion, or arteriosclerosis obliterans, a degenerative lesion. The only way that these two conditions can be distinguished with certainty is by histologic examination of a diseased vessel, but a high degree of accuracy in differential diagnosis may be achieved if the information in table 1 is kept in mind.

TABLE 1.—*Differential Diagnosis of Arteriosclerosis Obliterans and Thromboangiitis Obliterans*

Distinguishing Features	Thromboangiitis Obliterans	Arteriosclerosis Obliterans
Age at onset of symptoms, yrs.	Almost always less than 50	Almost always more than 40
Sex	99 per cent males	83 per cent males
Involvement of upper extremities	40 per cent of cases	Rare
Presence or history of superficial thrombophlebitis	40 per cent of cases	Never
Roentgenographic calcification of arteries	Absent	Present in 70 per cent of males
Hypertension	Rare in early years of disease	Present in 35 per cent of cases
Diabetes mellitus	Rare in early years of disease	Present in 20 per cent of cases
Plasma lipoids	Usually normal	Frequently elevated especially in younger patients

The age of onset of symptoms will usually distinguish between the two conditions. The presence of, or a good history of, superficial thrombophlebitis and the presence of involvement of arteries of the upper extremities almost certainly indicates thromboangiitis obliterans but absence of these two manifestations does not exclude thromboangiitis. The presence of arterial calcification, diabetes mellitus, lipemia, or hypertension almost certainly indicates arteriosclerosis obliterans, but the absence of these conditions does not exclude arteriosclerosis.

Two less common occlusive arterial diseases of the extremities, arterial embolism and simple arterial thrombosis, are seen usually because of acute rather than chronic arterial occlusion, but they may be encountered later because of residual ischemia of limbs resulting from persistent arterial obstruction. Arterial embolism is usually associated with one of three serious heart diseases: chronic auricular fibrillation, recent acute myocardial infarction, or vegetative endocarditis, or is associated with an aneurysm proximal to the site of occlusion. Simple arterial thrombosis is rare except in association with polycythemia vera, and frequently the diagnosis can be made only by histologic examination of the affected vessels.

Acrosclerosis may be complicated by occlusion of the digital arteries and even gangrene, but in such cases the scleroderma, which is not seen in other arterial diseases, is a distinguishing feature. A rare cause of chronic occlusive arterial disease is chronic occupational trauma. The dominant hand of farmers or mechanics may be the site of such occlusion when the hand is subject to much constant or vibrating pressure. One or more fingers may be affected by moderate to severe ischemia, and frequently pulsations are absent in the ulnar or radial arteries. Occasionally thrombotic occlusion of arteries occurs in patients who have cervical ribs.

There should be no difficulty in distinguishing Raynaud's disease, other arteriospastic disturbances, erythromelalgia, venous insufficiency, and lymphangitis, as well as gout, arthritis, mechanical derangements, primary neurologic conditions, and other nonvascular disorders of extremities from occlusive arterial disease, because none of these produce absence or impairment of arterial pulsations or postural color changes. In coarctation of the aorta pulsations are frequently absent in the arteries of the lower extremities, but there are no symptoms or other manifestations of arterial insufficiency.

Treatment

Thirty years ago there was essentially no treatment for chronic occlusive disease of the peripheral arteries. Now the general practitioner and even the specialist are confronted with so many methods of treatment that the choice becomes a real problem. One can easily infer that the number of procedures which have been advocated in recent years indicates that there is no real satisfactory method of treatment. It is well known that both thromboangiitis obliterans and arteriosclerosis obliterans are organic diseases characterized by episodes of essentially irreversible arterial obstruction. Between episodes the collateral circulation tends to increase gradually and compensate to some degree with or without treatment. A particular method of treatment may get undeserved credit if it is used at the right time. A common denominator of many of the advocated methods of treatment is rest in bed in a warm environment. It is possible that this is more important than the specific procedures or drugs which are added. However, it is only fair to say that newly advocated methods of treatment should not be rejected after only a superficial trial or solely on grounds that they are theoretically unsound.

Although the chronic occlusive arterial diseases are organic, they are commonly associated with spasm of the remaining intact arteries and particularly the arterioles. Even if these vessels are in normal tone, circulation can be improved by arterial and arteriolar dilatation. This principle is the basis for many of the methods of treatment which are used. Other important features in consideration of treatment are that ischemic tissue is very vulnerable to mechanical, thermal, and chemical trauma; that gangrenous and ulcerative lesions are almost always secondarily infected; and that pain is usually a prominent and stubborn symptom.

The general principles of treatment which apply to all types of chronic occlusive arterial disease are given in table 2. The best management is achieved

TABLE 2.—*Principles of Treatment of Peripheral Occlusive Arterial Disease*

Arrest the progress of the disease
Dilate uninvolved arteries and arterioles
Increase circulation mechanically
Relieve pain
Instruct in prophylaxis against injury of ischemic tissue
Treat ulceration and gangrene

through the cooperation of the internist and the surgeon, since medical and surgical methods of treatment are supplementary and not competitive. In general, there is no essential difference in the treatment of thromboangiitis obliterans and arteriosclerosis obliterans. The tissues of the extremities in arteriosclerotic patients have less capacity to heal, ischemic neuropathy is more common, and the prognosis as to life and after operation is poorer because of the frequent association of visceral arterial lesions and a greater tendency to progressive thrombosis in affected arteries. These factors may influence the choice of procedures to some extent and also the duration of conservative treatment in cases in which gangrene is present.

Procedures used to arrest the progress of the disease are given in table 3. While they may not always be effective, they represent the summation of our ability to attack this phase of the problem.

TABLE 3.—*Procedures Used to Arrest the Progress of the Disease*

Cessation of use of tobacco
Fungous control
Control of lipemia
Control of diabetes
Control of polycythemia
Anticoagulants

Tobacco is certainly a vasospastic agent and also probably a basic etiologic factor in almost all cases of thromboangiitis obliterans. Abstinence from tobacco should be insisted on, and there should be no compromise on this point. The role of dermophytosis as an etiologic factor in thromboangiitis is questionable but not entirely disproved, and in any event lesions caused by the fungi may be the starting point for ulceration and gangrene in ischemic extremities. Hence, fungous infections should be treated actively and prophylactically in susceptible individuals. However, strong fungicides and keratolytic agents should be avoided.

The control of lipemia in arteriosclerosis obliterans is not very satisfactory at present. Low fat, low cholesterol diets, besides being of questionable theoretic value, are not usually effective and are difficult to adhere to for long periods. Thyroid extract in subtoxic doses may be effective, and choline chloride has been found of value by some investigators. It is hoped that the better methods for control of disturbed lipoid metabolism will be developed in the near future.

Heparin and dicumarol are usually not of practical value for prevention of thrombosis in chronic occlusive arterial disease because of the difficulty of safe and satisfactory administration for long periods of time and the uncertainty as to when the next episode of occlusion may recur. These anticoagulants are of value after acute arterial thrombosis and during periods when thrombosis is progressing or recurring frequently.

Procedures used for vasodilatation are given in table 4. For hospital patients an environmental temperature of 80 to 85 F. produces considerable reflex vasodilatation. The use of heat cradles and heat

TABLE 4.—*Procedures Used for Vasodilation*

Warm environmental temperature, general and local
Foreign protein (typhoid vaccine) by vein
Hypertonic solution of sodium chloride by vein
Ethyl alcohol by mouth
Anesthetization of sympathetic nerves or ganglia
Tetra-ethyl-ammonium chloride
Regional sympathetic ganglionectomy

boxes for affected extremities is of some value, but the temperature of the air in these should be kept at less than 92 F., and the heating elements should be protected so that the patient cannot come in contact with them in any way. Parenthetically, the use of cold packs or refrigeration has no place in the treatment of chronic occlusive vascular disease except that refrigeration anesthesia may be of value when a limb must be sacrificed, and then only if the risk of operation is great or if there is much infection or toxemia from gangrene. Foreign protein given intravenously, which formerly was much used in thromboangiitis obliterans, is being employed less often. Intravenous administration of hypertonic solution of sodium chloride is still being used in some eastern clinics but has never been much favored in other parts of the country. Ethyl alcohol is a fairly good and simple vasodilator but its effect is somewhat transient. Local anesthetization of sympathetic nerves or ganglia and administration of tetra-ethyl-ammonium chloride are of little value in treatment because the effect is so transient, but they are of some value in testing for the degree of possible vasodilatation.

Regional sympathetic ganglionectomy has been gaining favor in the treatment for chronic occlusive disease of the peripheral arteries. This is partly because the vasodilatation produced by it is essentially permanent and partly because improvements in surgical technic have reduced the postoperative mortality rate and even the postoperative complications almost to zero. The effects of sympathectomy are maximum in the digits, somewhat less in the feet, hands, and skin of legs and arms and probably none

at all in large muscles. Therefore, one should not expect relief of claudication in the calf or thigh from the operation. The immediate beneficial effects are commonly relief of pain in digits and rapid healing of ulcers, and there is a permanent lessening of the liability to subsequent ulceration and gangrene. Sympathectomy does not prevent arterial occlusions caused by the disease. At present a combination of regional sympathetic ganglionectomy, cessation of smoking, and careful protection of ischemic extremities against trauma is probably the best basic treatment in almost all cases of thromboangiitis obliterans. In arteriosclerosis obliterans sympathectomies are being done more frequently than formerly, However, the cases still should be selected carefully, since in many instances the surgical risk is increased owing to visceral vascular lesions and there is some risk of arterial thrombosis in extremities during the immediate postoperative period. Sympathectomy does not relieve pain caused by ischemic neuropathy of large nerve trunks.

Three types of apparatus have been used to increase the circulation by mechanical means, namely the pavex alternating suction and pressure machine, the intermittent venous compression apparatus, and the oscillating bed. At best these are only adjuncts to other methods of treatment. The first has been almost abandoned, and the second is of doubtful rationale and is being used less and less. The oscillating bed, which is merely a modification of the old postural exercise carried out without effort by the patient, seems to be helpful in some cases of severe ischemia and is still being used in most hospitals where it is available.

Most patients who have chronic occlusive disease of the peripheral arteries come to the physician seeking relief of pain which may be severe, constant, and very difficult to control. There are essentially three types of pain: intermittent claudication, pain in terminal portions of the extremity due to severe ischemia, ulceration or gangrene, and pain of ischemic neuropathy. Intramuscular injections of tissue extracts, particularly pancreatic tissue extract, have been used for intermittent claudication. Their action is not well explained, but they seem to be of some value in about 50 per cent of cases, and they are usually worth a trial when claudication is the chief or only symptom. Various combinations of the other drugs mentioned in table 5 may be necessary when there is persistent pain, but the possibility of addiction to opiates, demerol, or alcohol must be kept in mind.

Ischemic neuropathy may produce severe pain which is difficult to control even with opiates and demerol, and the pain may persist even after high amputation. Some benefit in cases of ischemic neuropathy has been obtained by injection of 1 to 2 per cent solution of ammonium sulfate into peripheral nerves or sensory nerve roots, although experience is insufficient for adequate evaluation of this procedure to date. Injection of alcohol into nerve roots or peripheral nerves is not advisable. Surgical section or crushing of peripheral nerves in the lower third of the leg is a rational procedure for relief of severe pain in the foot or toes but results have been rather disappointing, and there is always a risk of nonhealing of the surgical wounds.

TABLE 5.—*Control of Pain*

Tissue extracts
Barbiturates
Salicylates
Opiates
Demerol
Ethyl alcohol by mouth
Anesthetization of peripheral nerves or nerve roots with procaine or ammonium sulfate
Surgical section or crushing of peripheral nerves
Amputation

Procedures used in the treatment of ischemic ulceration and gangrene are given in table 6. The best treatment is prevention. It is still rather disquieting that more than 50 per cent of the ulceration and gangrene seen in chronic occlusive peripheral arterial disease is initiated by minor avoidable injury, burns from hot water bottles and electric pads or other well intentioned but misguided therapy. Application of strong antiseptics, corn cures, keratolytic agents, irritating ointments, and solutions is strongly contraindicated for ischemic extremities. To remove surgically an ingrown toe nail, corn, or callus from an ischemic foot is to invite disaster. All patients with ischemic extremities should be instructed in the care of their feet and the avoidance of all minor as well as major injuries.

TABLE 6.—*Treatment of Ulceration and Gangrene*

Prophylaxis: avoidance of mechanical, thermal and chemical trauma
Fungous control
Warm soaks: bland solutions
Wet dressings: bland solutions
Tyrothricin locally
Sulfonamides orally
Penicillin parenterally
Powdered blood cells
Debridement of gangrenous tissue
Amputation of digit
Amputation of limb

The patient who has gangrene or ulceration is best treated in a hospital. The extremity should be kept at a level with the hip and neither elevated nor dependent. Where gangrene or ulceration is present, infection is also present and the parenteral administration of penicillin and oral administration of sulfonamides alternately or in combination may be of considerable value. Wet dressings of tyrothricin solution (0.05 per cent) may be used on infected

ulcers. The use of warm soaks in boric acid solution or 1 to 9,000 or weaker solution of potassium permanganate and the use of warm but never hot wet dressings may facilitate drainage and hasten sloughing. Ointments are usually of little value. When ulcers are clean but indolent, powdered blood cells may expedite healing. Gangrenous tissue may be débrided but only after it is well demarcated and has begun to separate spontaneously. In recent years more amputations of partially gangrenous toes have been carried out successfully. The surgeon should wait until signs of infection have disappeared from the site chosen for the incision, and the wound should be closed loosely. Parenteral antibiotic therapy before and after amputation has been of considerable help in combating infection and promoting healing. However, there is still some risk of nonhealing, particularly in arteriosclerosis obliterans.

When gangrene extends into the foot, conservative treatment is of little value and amputation of the leg will be necessary .The transmetatarsal amputation rarely leaves a useful foot. The sites of election for amputation are through the midcalf region and through the lower third of the thigh. The best test for selection between these two sites from the standpoint of adequacy of circulation below the knee is to make the incision for amputation through the midcalf without a tourniquet. If free bleeding from muscles is encountered, the amputation can be completed at that site. If there is little bleeding and the muscle is pale, this site should be abandoned, and amputation should be done above the knee, where healing will almost always occur even though the occlusion extends into the iliac artery.

In the last few years several new methods of medical treatment have been advocated enthusiastically for chronic occlusive peripheral arterial disease (table 7). Unfortunately, the results described by the proponents of these methods have not been confirmed. At the Mayo Clinic we have failed to achieve subjective relief or objective evidence of increase in circulation from use of histidine and vitamin C, ether administered intravenously, or intra-arterial injections of histamine. The good results reported for vitamin E could not be confirmed by a well controlled study which was carried out at the Post Graduate Medical School in New York City. Priscol or priscoline (2–benzyl–4, 5–imidazoline hydrochloride) has been shown to be a vasodilating drug but has been found to be rather disappointingly ineffective in the treatment of occlusive arterial disease, and its administration is sometimes attended by disagreeable side reactions. However, it may be worthy of further study and evaluation.

TABLE 7.—*Newer Drugs of Questionable or Unproved Value*

Ether given intravenously
Histidine and vita min C
Priscol
Vitamin E
Histamine given intra-arterially

Finally, I should like to make a plea for early diagnosis and institution of adequate active and prophylactic treatment in cases of chronic occlusive peripheral arterial disease. If this is done, much suffering, gangrene, disability, and economic loss can be prevented.

Summary

The diagnosis of chronic occlusive disease of the peripheral arteries is not difficult if the physician has a high threshold of suspicion, for its presence when patients have pain, ulceration, gangrene, changes in temperature or discoloration in an extremity. The most important physical sign is impairment of pulsations in the peripheral arteries. Postural color changes are a good rough indication of the degree of ischemia. There are two important chronic occlusive peripheral arterial diseases, thromboangiitis obliterans and arteriosclerosis obliterans, and almost always they can be distinguished clinically. The general principles of treatment can be classified under the broad headings of: (1) efforts to arrest the progress of the disease, (2) procedures to produce dilatation of uninvolved arteries and arterioles, (3) efforts to increase circulation by mechanical means, (4) procedures for direct relief of pain, (5) instruction in prophylaxis against injury of ischemic tissues, and (6) treatment of ulceration and gangrene.

AMERICAN HOSPITAL ASSOCIATION TO MEET IN ATLANTIC CITY IN SEPTEMBER

The fifty-second annual convention of the American Hospital Association will be held in Atlantic City, N. J., September 18–21. Headquarters will be the Hotel Traymore. Meeting with the Association will be the Women's Hospital Auxiliaries, the Architects and State Planning Directors, the American College of Hospital Administrators, and the American Association of Nurse Anesthetists.

Insulin and Insulin Mixtures*

By B. J. PETERS, M. D.
Milwaukee

B. J. PETERS

An assistant professor of clinical medicine at Marquette University School of Medicine, Doctor Peters received his M. D. degree from that institution in 1938. He was a resident at the Milwaukee County General Hospital from 1937 to 1941, at that time entering the Army Medical Corps. He is a consultant in internal medicine at the Veterans Administration Hospital, Wood, is chief of medicine at the Milwaukee County General Hospital and maintains a private practice in internal medicine.

IN THE regulation of a diabetic patient, if diet alone does not accomplish the necessary improvement, insulin therapy has to be instituted. Whenever insulin is administered to any diabetic person, one should thoroughly instruct the patient in all its details. Education of the diabetic patient and, if a youngster, of his relatives is an essential in diabetic management.

There are four insulins in common usage at present. Many others have been developed in the past 25 years, but regular, crystalline, globin, and protamine zinc insulin are the ones used most exclusively in practice. N.P.H. 50 is another insulin recently introduced but is not available for general use. The strengths of insulin on the market have been many; the most often used are the U40 and U80 strengths. Confusion still exists in the minds of patients and physicians as to the meaning of these figures. This confusion can be lessened if one remembers that, unit per unit, all insulin is the same. The difference in the two is that in a given volume there are double the number of units in the U80 as compared to the U40.

In selecting an insulin for a patient, one must take into account the eating habits, work habits, and the activities of the individual. When choosing insulin one should select an insulin that has its peak of activity when the individual ingests the greatest quantity of food and whose action tends to decrease when activity is decreased and food ingestion is less. It may be difficult or impractical for many patients to follow standardized eating habits, and, in these, multiple small feedings may be needed. Our aim is to get the patient controlled as close to a normal state as we can. We should attempt to have as few with glycosuria and hyperglycemia as possible. The advantages and disadvantages of the different insulins are as follows:

Regular Insulin

This insulin should not be used for routine regulation of diabetes. It is the original form of insulin. All the modifications of insulin stem from it. The response to a single subcutaneous dose begins shortly after injection, reaches its peak in from two to four hours after injection, and is exhausted in about six to eight hours. These rates of action are about the same for both regular and crystalline forms of insulin. Crystalline differs from regular in that it is freer from foreign protein and acts about two hours longer. The usage of these insulins should be limited to emergencies, acidosis, infection, trauma, and operations. They can be used to supplement long acting insulin, and can be given to those patients requiring large amounts of insulin for control, as these are put up in strengths high enough to permit the administration of several hundred units in one injection. In those patients in whom adequate control with depot insulin is impossible, multiple injections of regular insulin may be necessary for more uniform control.

Protamine Zinc Insulin

Protamine zinc insulin is the insulin that has enabled many diabetic patients to eliminate multiple injections. Most diabetic persons work, and an insulin that need not be administered more than once daily is indispensable in their treatment. One injection may be all that is needed, and this furnishes a constant, even supply of insulin that has a continuous maximal action at all times. It begins its action within four to six hours, and its peak of action is within 12 to 20 hours after injection. Its effect is usually exhausted in 48 to 72 hours. The fasting blood sugar level is dependent on the dose of protamine used. There are certain disadvantages; one is that protamine zinc insulin in sufficient dose to keep a patient sugar-free during the day will make him go into hypoglycemia in the early morning hours. Secondly, one finds that those needing more than 40 units of insulin per day are difficult to control on protamine zinc insulin alone. Some introduce separate extra doses of regular insulin for better control, but this involves multiple injections daily, the very thing protamine zinc insulin was designed to avoid. Another disadvantage is the local hypersensitivity reactions to the protamine.

Globin Insulin

This is another long acting insulin which is suitable for mild or moderately severe diabetics, re-

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

quiring 50 units or less daily and in those with regular dietetic habits only. Globin insulin is a combination of insulin with globin, which is a simple protein derived from beef red cells. It is an insulin of prolonged activity. It acts more quickly, and its action is less sustained than protamine. The onset of action is within an hour and it is slow, with a peak of action between 6 and 10 hours, and its action is completed in 15 to 24 hours. Its action can be closely imitated by mixtures of protamine zinc insulin and regular insulin containing a ratio of 2:1 (2 regular to 1 protamine zinc insulin).

The disadvantages of globin insulin are as follows: (1) patients with severe diabetes cannot be controlled on one dose of globin, especially those needing more than 50 units daily; (2) globin is too short in duration to cover nocturnal insulin requirements in severe diabetes; (3) some complain of burning at the site of injection; (4) globin insulin fails to permit the overlapping of effect from day to day, which is so essential in severe diabetes.

Insulin Mixtures

During the past two and one-half years we have used extemporaneously prepared mixtures of regular insulin and protamine zinc insulin. These mixtures have permitted more highly individualized control of diabetes, as each patient could be controlled by a mixture made to his individual requirements. This procedure enabled us to control a greater number of diabetic patients than by the use of the other depot insulins. The most useful mixture appeared to be that made from approximately 2 parts of regular insulin (or a little more) to 1 part of protamine zinc insulin (referred to as a 2 to 1 mixture). We found that the use of one fixed ratio of insulin mixture was not adequate for control of all the diabetic persons. The required range of ratio of mixtures was between 1 part of regular insulin to 1 part of protamine zinc insulin and 3 parts of regular insulin to 1 part of protamine zinc insulin.

The action of the insulin mixture begins within an hour after administration and a peak is reached in six to eight hours after the injection, and its action is completed in about 48 hours. Most patients prefer the use of mixtures because one or more injections are eliminated. When using mixtures the dosage of regular insulin was adjusted by the character of the glycosuria, as obtained from urine studies during the day. The fasting blood sugar served as a guide for the dose of protamine zinc insulin in the mixture.

The important disadvantages in the use of insulin mixtures are (1) that the patient must manufacture his own dose every time he takes an injection; (2) their action is less predictable than either that of unmodified insulin or protamine insulin when given alone or as separately injected doses in the morning before breakfast; (3) they appear to be easily inactivated by infection; and (4) there is necessity for close attention to the details of dietary management by the patient.

In prescribing any insulin one should also prescribe the approved standard syringes to match the strength of insulin used. The syringe with green markings should be used for U80, the one with red markings for U40.

Finally, it can be said that any of the insulins can be used, providing one knows the action and limitations of the insulin being used.

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY OFFERS PLASTIC SURGERY AWARD

The Foundation of the American Society of Plastic and Reconstructive Surgery offers as its 1950 award $500 (first prize of $300; second prize of $200) and a certificate of merit for essays on some original unpublished subject in plastic surgery.

Competition is limited to residents in plastic surgery of recognized hospitals and to plastic surgeons who have been in such specific practice for not more than five years.

The first prize essay will appear on the program of the forthcoming annual meeting of the American Society of Plastic and Reconstructive Surgery, to be held in Mexico City, November 27–29, 1950. Essays must be in before August 15, 1950.

For full particulars write the secretary, Dr. Clarence R. Straatsma, 66 East Seventy-Ninth Street, New York, New York.

Hemorrhagic Disturbances in Childhood*

By HEYWORTH N. SANFORD, M. D.
Chicago

H. N. SANFORD

A graduate of Rush Medical College, Doctor Sanford served on the staff of the department of pediatrics of that institution from 1928 to 1940. Since 1944 he has been Rush clinical professor of pediatrics at the University of Illinois College of Medicine and is attending pediatrician at Presbyterian and Cook County hospitals, Chicago.

CLOTTING of the human blood is nature's mechanism for protecting the individual from abnormal blood loss if there is a break in a blood vessel. A failure of the blood to clot promptly endangers the life of the individual and may even cause death if not promptly corrected. This natural phenomenon is accomplished by changing the soluble blood protein—fibrinogen—which is always present in the plasma, to an insoluble substance—fibrin—when blood is shed. This new protein substance results in a firm clot if coagulation is normal and in an unfirm one if coagulation is abnormal.

To accomplish this a reaction occurs between calcium and prothrombin, which exist naturally in the plasma, and the blood platelets, which agglutinate at the point of trauma. This reaction causes a new substance to be formed, called "thrombin," which causes the fibrinogen to change into fibrin. There are also balancing substances in the normal blood plasma which keep this mechanism in control. These are called inhibitors, of which the best known and only important one for our study is called "heparin."

Remembering this physiologic action, one may classify hemorrhagic disturbances into those in which some of these coagulation elements may be at fault or wanting, namely, blood platelets, prothrombin, calcium, fibrinogen, and heparin and, the second large group of those in which none of these coagulation elements can be demonstrated to be at fault. In these, the disturbances are presumed to be in the walls of the small blood vessels and are called "vascular coagulation disturbances" (table 1).

In the first group there are disturbances of the platelets. These may be due to quantity or total number. These disturbances may be found in diseases in which the bone marrow is altered, as in anemias, leukemias, and tumors of marrow origin and in diseases like hemolytic disease of the newborn, in which the megakaryocytes that are the forerunners of the blood platelets are crowded out by other blood cell forms. Also, in certain liver disturbances there

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TABLE 1.—*I. Hemorrhagic Conditions In Which Known Coagulation Elements Can Be Demonstrated*

- A. Platelets
  - a. Quantitative
    - 1. Interference with function
      - a. Tumors (bone marrow)
      - b. Anemia (aplastic and pernicious)
      - c. Erythroblastosis
      - d. Liver disturbance (also vascular)
    - 2. Destruction
      - a. Bacterial as, streptococcus, diphtheria, typhoid, influenza, tuberculosis and syphilis
      - b. Chemical as benzol, arsenic, radium, and x-ray
    - 3. Hereditary thrombocytopenia
    - 4. Essential thrombocytopenia
  - b. Qualitative
    - 1. Hemophilia
    - 2. Hereditary thromboasthenia
- B. Prothrombin
  - 1. Hemorrhagic disease of newborn
  - 2. Liver and biliary disturbances
  - 3. Chemical, as Aspirin, penicillin, and sulfonamides
- C. Heparin
  - 1. Pseudohemophilia
  - 2. Obscure hemorrhages associated with
    - malignant blood diseases; endocrine disturbances; menorrhagia; and chemicals, as aminopterin
- D. Fibrinogen
  - 1. Congenital fibrinogenemia
  - 2. Liver damage, as chloroform poisoning, acute yellow atrophy, carcinoma, and tuberculosis
- E. Calcium (very doubtful)
  - 1. Congenital deficiency of calcium
  - 2. Acquired calcium deficiency

II. Vascular Purpura, In Which No Known Coagulation Element Can Be Demonstrated To Be At Fault

- A. Mechanical, as venous stasis, pertussis, and tumors
- B. Malnutrition, as vitamin C and perhaps other vitamin deficiencies
- C. Essential or anaphylactic purpura
  - 1. Purpura simplex, anaphylactic etiology rarely demonstrated
  - 2. Purpura rheumatica, anaphylactic etiology occasionally
  - 3. Purpura abdominalis, anaphylactic etiology usually

will be a deficiency of platelets. The blood platelets may also be destroyed by bacteria and certain chemicals.

There are also found certain families that are naturally deficient in platelets, in which the condition is called "congenital thrombocytopenia," and there is the disease called "essential thrombocytopenia," for which there is no known cause but in which the platelets decrease until faulty coagulation takes place. Essential thrombocytopenia may be caused by an increased activity of the reticuloendoethelial system, particularly the spleen, which destroys the platelets, or it may be caused by a faulty formation or lack of megakaryocytes in the bone marrow. The only treatment that is of value for the last type and all of the other forms of thrombocytopenia except the splenic form are transfusions. The splenic form is best helped by a splenectomy. The two types may be differentiated by an examination of the bone marrow. If the marrow shows good megakaryocyte formation, the difficulty is in the reticuloendothelial system, and a splenectomy will benefit the patient. If the bone marrow indicates that megakaryocytes are poorly formed or absent, splenectomy is useless, and transfusions will be of greater benefit.

Secondly, there is faulty coagulation in which the platelets are normal in number but do not disintegrate promptly. This results in a very unfirm clot and considerable bleeding. These conditions are called "qualitative platelet defects." An example of this is hemophilia, in which case the individual is born with this defect as an inherited condition. While many remedies have been tried to help hemophiliac persons, the best means of tiding the patient through one of these bleeding episodes is by transfusions. Somtimes the globulin fraction of whole blood will better the clot formation. Lately we have found that injections of histamine will help the disintegration of the platelets. This is given in increasing amounts intravenously in salt solution, beginning with 0.1 mg. and increasing daily to 1.0 mg. This has stopped the bleeding promptly in 5 hemophiliac patients in our clinic. It is not a cure, because 2 of these boys have returned with other bleeding episodes, but these episodes have been shorter in length of bleeding and have been considerably farther apart in time. While we do not wish to put forth this treatment as a cure for hemophilia, it does help many of these boys, and is sparing of the immense amounts of blood that have been formerly necessary to give us transfusions to stop the bleeding in these unfortunate individuals.

An insufficiency of prothrombin may be found after the use of certain drugs, as aspirin, and antibiotics, as penicillin and the sulfonamides. However, these instances are very uncommon, and may be dismissed as ever a cause of prothrombin deficiency in infants and children except in very exceptional conditions. In the newborn infant there is a physiologic decrease in the prothrombin content of the blood for the first three days of life, due to an inability of the liver to form this substance at once. Unfortunately, this has been considered as the cause of the many hemorrhagic manifestations that occur in the newborn period. I do not believe that these are materially effected by this low prothrombin content of the blood in the newborn infant. The rather uncommon condition of severe bleeding in the newborn period, known under the blanket term as hemorrhagic disease of the newborn, may occasionally be due to an abnormal lowering of the prothrombin content of the newborn blood. In such instances in the presence of an actually low prothrombin level, vitamin K in quantities of 2 to 5 mg. will correct this condition. However, in many instances a transfusion will also be found to be necessary.

It has long been thought that the premature infant, which is known to have some hemorrhagic disturbances, might be even more deficient in prothrombin than the normal newborn child. This has not been found to be the case. Their bleeding is due more to an increased capillary fragility due to their immaturity. In our hospital we have not given vitamin K prophylactically to either premature infants or normal newborn infants for the last six years, and have encountered no more bleeding during this time than before vitamin K was given.

In older children a prothrombin deficiency may be found in disturbances of the liver or gallbladder system. These, of course, are helped by vitamin K. However their occurence is so rare in children that the condition is met with infrequently.

Fibrinogen may be deficient in certain liver disturbances but rarely ever is decreased sufficiently to cause any coagulation dysfunction. Calcium likewise is never decreased enough to be a cause of coagulation dysfunction.

Lately it has been shown that the balancing substance "heparin" may be in excess in certain instances. These so far to be observed are in the malignant blood diseases, as leukemias; in certain endocrine disturbances, as menorrhagia; and following the use of certain drugs of the antifolic acid antagonists, as aminopterin. Heparin in these individuals blocks some of the coagulation elements, namely, the phospholipids of the platelets, and is also antithrombic in some instances. The quantity of heparin existing in the blood may be indirectly estimated by protamine titration and, if in excess, may be itself blocked by the administration of toluidine blue or protamine sulfate.

Lastly, there are a great number of instances, actually two-thirds of all the hemorrhagic disturbances of infancy, in which none of the known coagulation substances can be found at fault. These are called vascular or allergic purpuras. They are all characterized by petechial hemorrhages and an increased fragility of the capillaries, as shown by the Rumpel–Leeds test. Some of these are due to malnutrition, as in scurvy, due to a lack of vitamin C. Others are due to some chemical substances or to bacterial infection, and some are due to an anaphylactic disturbance. The majority have no causation that can be demonstrated.

TABLE 2.—*Diagnosis and Treatment of Hemorrhagic Disturbances*

Method	Class of Disturbance	Treatment
Take bleeding and coagulation time	If these are lengthened, it is a disturbance of coagulation function	
	If these times are not lengthened it is a capillary or anaphylactic disturbance	
Platelet count	Over 100,000 is not a quantitative thromboplastic defect	
	Under 100,000 is a quantitative thromboplastic defect	Transfusion; splenectomy
Prothombin time	If under 50 per cent prothrombin is low	Vitamin K (2–10 mg.);
	If under 30 per cent is a prothrombin deficiency	Bile salts (occasionally)
Protamine titration for heparin	If over 0.140 mg. indicates an excess of heparin	Protamine sulfate (400 mg. in 24 hr.); toluidine blue (6–8 mg. per Kg.)
Centrifuge blood and take coagulation time of plasma	Low hematocrit means a primary blood disturbance, as anemia, leukemia, or infection	Treat primary cause
	Lengthened coagulation time with a normal platelet count, prothrombin time, and heparin titration is a qualitative platelet defect, as hemophilia	Histamine (0.1 mg. to 1.0 mg. in 6 daily inj.); plasma globulin fraction; transfusion
Vitamin C determination	If below 50 mg. is a preclinical scurvy	Vitamin C. (100–200 mg. day)
If all above are normal	Is a capillary or anaphylactic disturbance	Rutin; calcium; antihistamines; adrenalin; desensitization

Under the group sometimes spoken of as anaphylactic purpuras there is, first, a condition called "purpura simplex," in which the symptoms are only a mild self-limiting purpura; very rarely an anaphylactic causation or symptoms can be found. Another group is called "purpura rheumatica," in which with the purpuric manifestations there is bleeding into the joints. These are occasionally associated with wheals and other allergic manifestations, and an anaphylactic causation can be demonstrated. The last of the group is called "purpura abdominalis" and is characterized by purpura and bleeding from the bowel. In this form an anaphylactic etiologic factor can almost always be demonstrated, and it is associated with wheals and urticaria.

The treatment of all of these types of abnormal bleeding must necessarily depend on the cause. Malnutrition must be corrected and vitamin C and rutin administered. Bacterial foci must be eliminated, and offending chemicals withdrawn. If an anaphylactic etiologic factor can be demonstrated, desensitization may be of value. In severe instances tranfusions are of benefit, particularly if there has been any great loss of blood. Strangely enough, calcium seems to benefit many of these manifestations. As stated before, this has no direct result on the coagulation factors but seems to have a selective action in decreasing the permeability of the intracellular cement substance that holds the cells lining the capillaries together. It has been successfully demonstrated that these cells when bathed in calcium and an acid medium will be much less permeable. Table 2 shows the treatment and diagnosis.

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PHYSICIANS REMINDED OF NARCOTICS REGULATION

By July 1, all physicians registered under the Harrison Narcotic Act or under the Marihuana Tax Act must have effected reregistration. Very severe penalties may be invoked in case of failure.

If you have not received forms for separate registration and inventory of narcotics and marihuana, write immediately to the office of the Collector of Internal Revenue, Federal Building, Milwaukee 1. It is the responsibility of the physician to effect reregistration, make out inventories, and pay the annual tax or taxes. Physicians having two offices *must* register for both, as each office must have a separate registration number. Physicians in service are exempt.

Cancer of the Face and Oral Cavities*

By ERWIN R. SCHMIDT, M. D.
Madison

E. R. SCHMIDT

Doctor Schmidt, recipient of the Council Award of the State Medical Society in 1949, secured his medical degree from Washington University School of Medicine, St. Louis, in 1916. In 1923 he was appointed chief surgeon at Wisconsin General Hospital and has continued in that position as well as serving as professor of surgery at the University of Wisconsin Medical School. For ten years he was a member of the Council on Scientific Work of the State Medical Society.

CANCER is second to heart disease as a cause of death.[1] In the field of research many men are devoting their lives in the search for the cause of cancer, and great amounts of money are being invested in this project. In the clinical field, through governmental and private agencies, the public and the medical profession are being educated. A great deal of attention is being given to cancer in general, and especially to special cancers, such as of the breast, stomach, uterus, and, more recently, lung. If the material seen at the Wisconsin General Hospital is any criterion, cancers of the face, as well as cancers of the oral cavities, seem to need more attention.

Because of the physiology, embryology, and exposure, cancers of the oral cavities present some features that are important in the clinical-pathologic picture. Physiologically these areas are associated with great activity. They have a rich blood supply. They play a role in digestion, tasting, smelling, respiration, hearing, phonation, and appearance. Tissues for these functions present the basis for pathologic changes.

In the development of the head, the closure of the fissures and their fusion may include misplaced germ layers, which later give rise to dermoids, and, as in the closure of the second branchial cleft, remnants that seem grossly misplaced anatomically (figs. 1, 2, 3, 4 and 5).

The face and oral cavities are exposed to a great deal of irritation. The face, lips, and ears are exposed to the sun and wind; and the mouth suffers wear and tear from smoking, carious teeth, and ingestion of food and drink. Of all areas of the body, the face and oral cavities are most easily accessible to inspection. X-ray, special examinations, and biopsy will usually lead to an accurate diagnosis. The factors delaying a definite diagnosis are (1) delay in visiting the doctor and (2) treatment of lesions without a definite diagnosis. Unfortunately, the early lesions do not inconvenience the patient, and so he cannot be blamed for such a delay. For a delayed diagnosis by the physician there is no excuse. Biopsy will solve this problem in nearly every case.

Routine physical examinations, if thoroughly done, would be ideal. Judd[2] suggested an answer to the problem of early diagnosis: education of the doctors to make definite diagnoses with biopsy, and education of the dentists to recognize early changes in the mouth when people come to them for dental care. The American people are more conscious of dental hygiene than they are of periodic health examinations. The recent graduates in dentistry seem to be more alert in the diagnosis of early changes in the mucous membrane of the mouth.

The following observations are based on the material received at the Wisconsin General Hospital during the last twenty-three years.

Cancer is usually basal cell, squamous cell, or adenocarcinoma. Basal cell cancer is usually of the face. It is slow growing and does not metastasize to the lymph glands. It spreads like a fire and involves the tissue locally, leaving an ulcer with edges that are indurated and slightly everted and a base of necrotic tissue—a scab or granulation-like tissue that bleeds easily. Squamous cell carcinoma arises from the mucous membranes of the oral cavities. It develops locally but spreads to the lymph glands with varying degrees of rapidity, depending on the degree of malignancy. The ulcer has indurated,

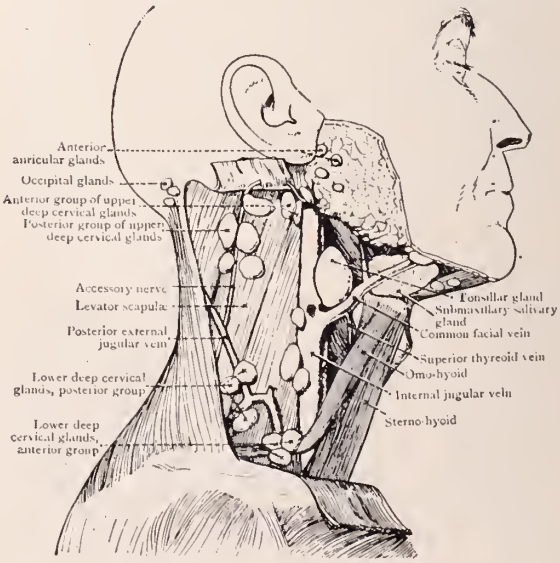

Fig. 1.—Lymphatic glands of the neck.

* Presented before the One Hundred Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

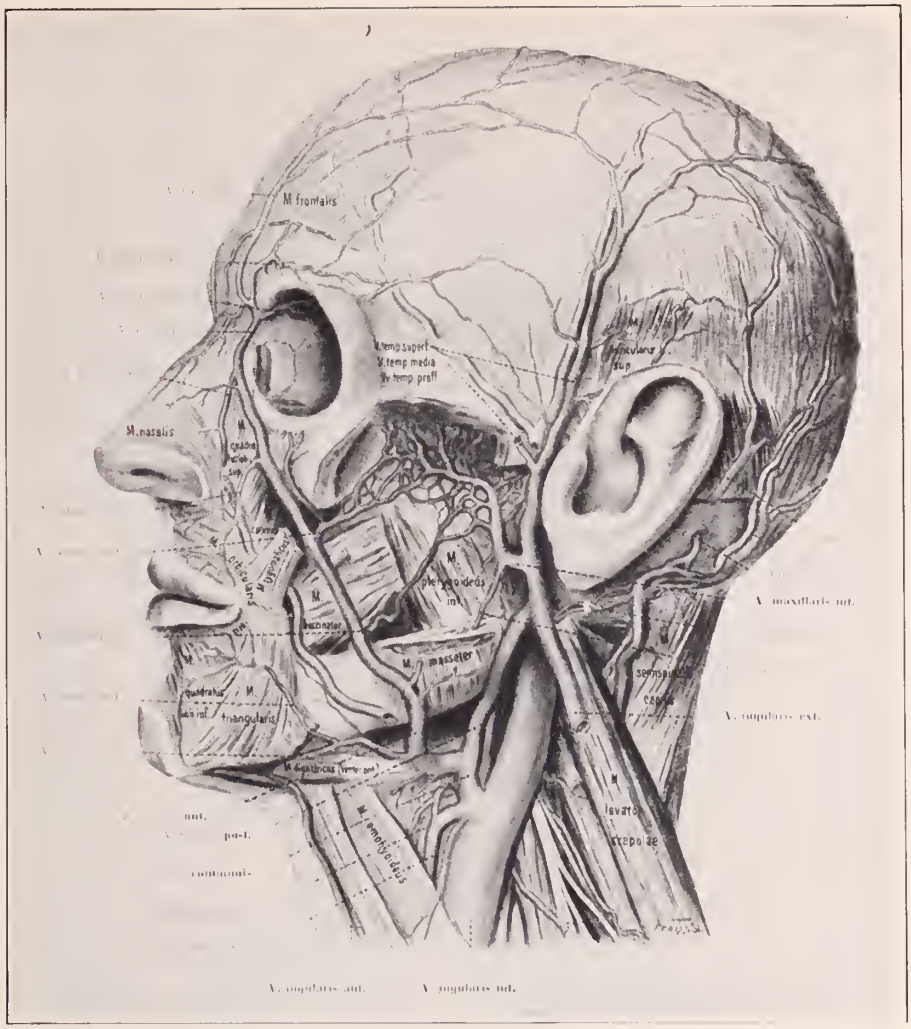

Fig. 2.—Veins of the neck.

everted edges with an indurated base covered with a firm, granulating looking tissue or necrotic tissue. Adenocarcinomas are rare. They usually arise in glandular tissue and for a time are covered with mucous membrane, and later ulceration occurs. The benign tumors are encapsulated, beneath the mucous membrane, and, because of pressure, later may erode through the mucous membrane; and they present an ulcer which shows signs of inflammation.

Malignant growths of the mouth anterior to the pillars are less malignant than those posterior to the pillars. The squamous cell or epidermoid carcinomas usually found in the anterior regions have more pearl formation and cornification than those found in the posterior areas. The posterior malignant growths have a higher malignancy grading. Those in the floor of the mouth and the root of the tongue, because of greater activity of the tissue, spread more often and show greater growth than a similar lesion of the side or dorsum of the tongue. Leukoplakia may be deceiving when biopsied. There may be several isolated malignant areas separated by a benign area. Epidermoid carcinoma of the alveolar margin may be of a flat type, involving a superficial area. The other type begins around a tooth. The tooth may become loosened and painful and then is extracted. The tooth socket does not heal and the bone is already invaded by the malignant process.

Syphilis of the tongue coincident with a malignant growth occurred up to 80 per cent in older statistics. Our experience shows that it is very low, but it should always be ruled out. All lesions that are ulcerated are associated with infection. Ewing[3] says that infection facilitates the growth of malignant processes and increases complications. In most cases of infected epidermoid carcinoma, streptococcal infection proceeds with the extension of the disease and often dominates the disease. Sections often show metastatic division of tumor cells around a focus of pus. Tumor tissue favors the growth of streptococci. Infection invades lymph pathways and facilitates the spread of carcinoma. Hyperemia opens blood ves-

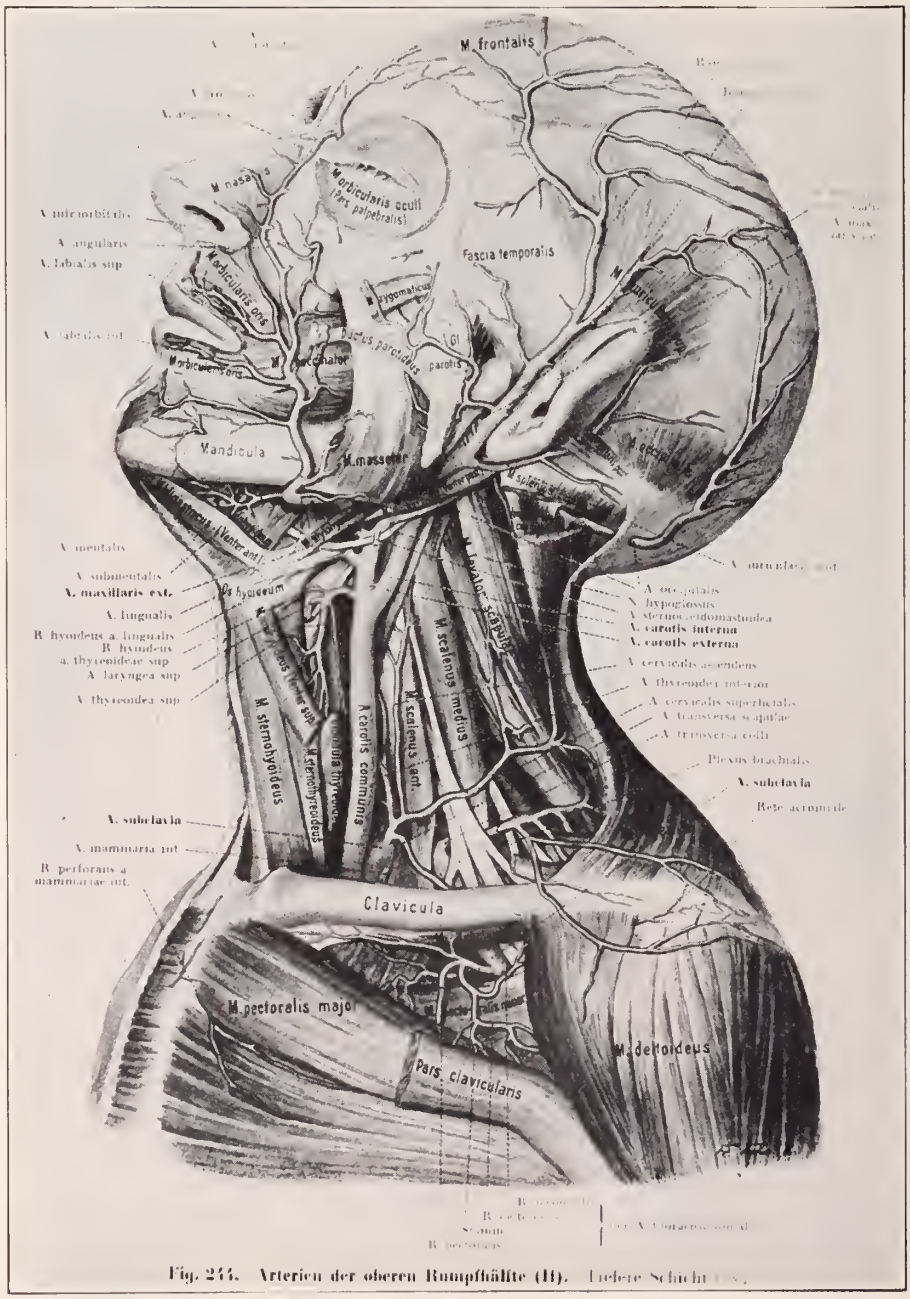

Fig. 244. Arterien der oberen Rumpfhälfte (II). Tiefere Schicht.

Fig. 3.—Arteries of the neck.

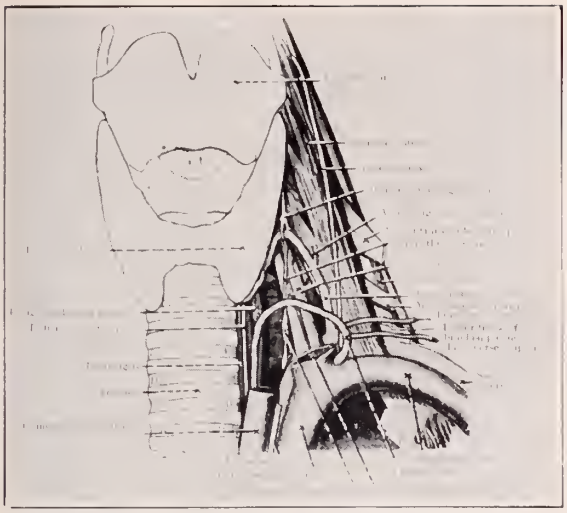

Fig. 4.—The posterior triangle of the neck.

sels. Local and general sepsis deplete the physiologic reserves of the patient. Pain is intensified, and radiation is nullified or becomes a detriment. Control of infection would seem to be paramount. With this control, progress of the malignant process is often temporarily checked.

The presence of a lymphatic collar in the neck made up of lymph glands and their vessels is a barrier to the lymphatic spread of carcinoma. It may be divided into the suprahyoid and infrahyoid groups. In early cases, only the suprahyoid region needs block dissection; in advanced cases, a complete block dissection of the neck is advisable.

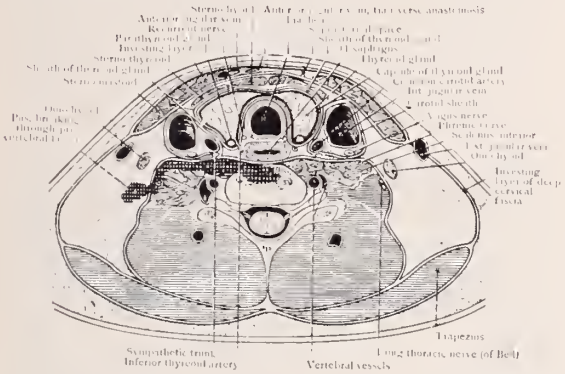

Fig. 5.—The fascial layers of the neck in a coronal section.

While the lymphatic spread is usually to the nearest lymph gland draining the area, the course of the drainage is diverted when a gland becomes blocked because a malignant growth has replaced the normal lymph gland structure and it no longer filters the lymph. This gives rise to bizarre spread to other lymph glands that do not seem anatomically correct.

In addition to the lymphatic spread, there may be local dissemination by continuity and contiguity. Ulcers are formed and are always infected, and these

Table 1.—Carcinoma of the Lip, 1940–1947, Inclusive

Number of Patients		157
Sex:		
Males	151	
Females	6	
Histologic Diagnosis:		
Squamous carcinoma	126	
No biopsy	28	
Basal squamous carcinoma	2	
Basal carcinoma	1	
Location:		
Upper lip	10	
Lower lip	136	
Both lips	11	
Size: Involvement of lower lip		
Largest group	1–2 cm.	
Next group	2–4 cm.	
Extension:		
Beyond lip	18	
Absent or not stated	139	
Involvement of Nodes:		
Nodes palpable		85
Biopsy of nodes done in	32	
Positive in	22	
Negative in	10	
Biopsy of nodes not done in	53	
Nodes not palpable or not stated		72
Distant Metastases		3
Type of Treatment:		
Chemosurgery	91	
X-ray	48	
Resection	19	
Node resection	22	
Jaw resection	3	
Block dissection (usually unilateral)	9	
Type of Treatment of Nodes:		
Resection	31	
X-ray	4	

are typical of malignant ulcers with everted, indurated edges, and bases that are indurated and covered with necrotic material. The degree of malignancy is important in the spread and mortality rate.

Our material consists of 1,408 cases in which the patients were treated in the departments of surgery and x-ray. Treatment in two departments occurred often in the same case. This is shown by the type of treatment in 157 cases of carcinoma of the lower lip in which the patients were hospitalized on the surgical service (table 1). They were treated as follows:

Chemosurgery	91
X-ray	48
Resections	19
Node resections	22
Jaw resections	3
Block dissections (usually unilateral)	9
	192

(There were 192 procedures on 157 patients.)

Since 1936 most of the superficial malignant growths of the face, lip, and neck have been treated by chemosurgery, under the direction of Dr. Frederic E. Mohs.[4] In the cases presented the malignant processes are of the lower lip. There are two groups: In group I are 247 patients observed for three years, and in group II are 197 patients observed for five years. Successful results were obtained in 92.8 per cent of the three year group and in 90 per cent of the five year group. The follow-up in cases in which the patients were treated by surgical procedures and x-ray is incomplete, whereas in the chemosurgically treated patients in the three year period 9.7 per cent were lost from observation and in the five year

Table 2.—Three Year and Five Year End Results of Cases of Cancer of the Lower Lip

These series include the cases of all patients with histologically proved squamous cell carcinomas, both early and advanced, previously untreated and recurrent, with and without metastasis, who were admitted to the chemosurgery clinic from July 7, 1936, to January 30, 1946, for the three year period and from July 7, 1936, to January 30, 1944, for the five year period.

	3 year period	5 year period
Total Number of Cases	247	197
Indeterminate group		
Patients dead from other causes without recurrence	29	37
Patients lost from observation without recurrence	24	23
Total number	53	60
Determinate group		
Total number	194	137
Unsuccessful results		
Patients dead as a result of cancer	9	9
Patients lost from observation with cancer	2	2
Patients living with cancer	3	3
Total number	14	14
Successful results		
Patients free from cancer for three years or more (first column) or for five years or more (last column)	180	123
Three year end results		
Total number of cases with successful results divided by the total number of determinate cases (180 + 194)	92.8%	
Five year end results		
Total number of cases with successful results divided by the total number of determinate cases (123 + 137)		90%

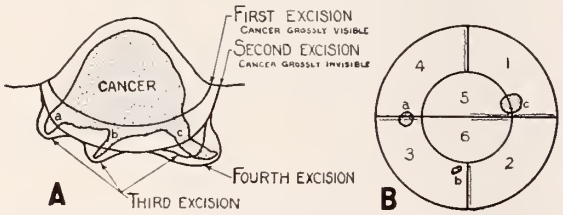

Fig. 6.—Plan of chemosurgical excision after the method of Dr. Frederic E. Mohs.

period 13.37 per cent were lost. In both instances there were no recurrences at the time of the last observation.

The knowledge gained from careful follow-up examinations by chemosurgery has resulted in the following procedures. Chemosurgical treatment destroys the lesion by careful fractional removal, removing the least amount of normal tissue and finding extensions of the malignant process which are overlooked when surgical removal is done. With x-ray a large field has to be exposed in order to get these extensions, and more tissue than is necessary has to be included. Beyond the area removed with chemosurgical procedure, the tissue is uninjured, soft and pliable and has normal blood supply. The absence of any palpable lymph nodes demands careful follow-up over a period of months. Where lymph nodes appear or are present when first seen, a block dissection is carried out. Whether the dissection is suprahyoid or complete depends on the palpatory findings before operation and the findings at operation. All block dissections interrupt the lymph channels as far from the primary source as possible. A widespread local lesion is treated by wide excision

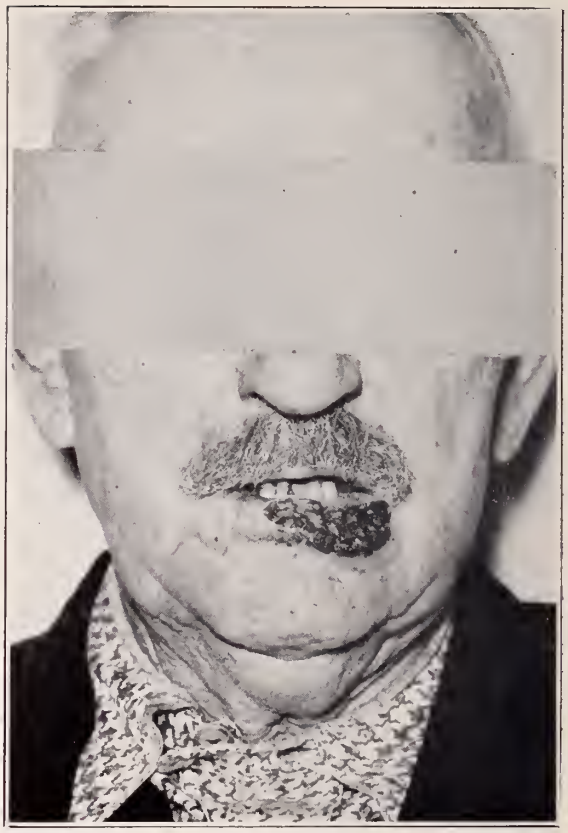

Fig. 7.—Lesion as seen in the patient.

surgically and plastic repair if possible at once; if not, the plastic repair may wait until after the lymph glands have been removed, and the original site of removal is watched for local recurrences. If there are no recurrences, the plastic repair may be done.

Discussion

The lymphatic gland spread may be dealt with either primarily or after the local lesion has been excised. Judd and New[2] advise excision of the primary lesions first and the nodes in a few days, before the local reaction takes place. They believe excision of the nodes changes the direction of the

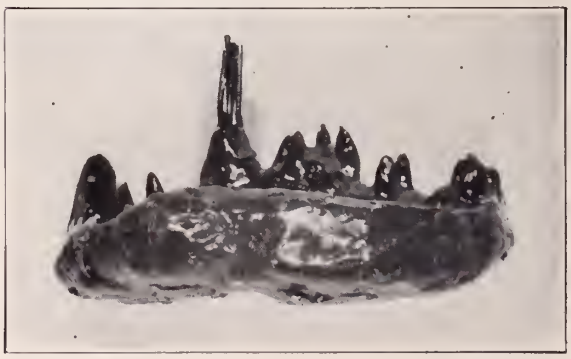

Fig. 8.—Model showing extensions of the carcinoma.

Fig. 9.—*A*, Squamous cell epithelioma of the lower lip with metastases to the submental region and the mandible; *B*, same as *A*, more advanced; *C*, lateral view of epithelioma of lower lip with extension to the mandible and neck. *D*, pedicle graft to defect following operation.

Fig. 10.—*A*, recurrent squamous cell epithelioma involving the soft tissue of the cheek and lip; *B*, same as *A*, following excision with cautery; *C*, local recurrence.

Fig. 11.—*A*, a wide resection of the mandible and cheek and lip; *B*, median view of extensive resection of lower jaw, lip, and face.

Table 3.—Number of Patients Treated
1928–1948

(Figures are approximate)

Face	289
Lip	272
Mouth	343
Cervical metastases (primary unknown)	60

lymph flow, and it is harder to get good exposure following neck dissections. They also recommend in grade IV malignant processes that the lymph nodes can be better treated by x-ray or radium.

Ewing[3] says control of lymph node metastases depends on clinical experience with consideration of known pathologic facts. All tumors have a premetastatic period when the nodes are not involved. This varies with the individual and the type of tumor. Ulceration and infection aid spread and make the presumption of spread more likely. He quotes from Bloodgood, who found 68 per cent of his patients with excised carcinoma of the lip to have no nodes, and from Broders, who found in 257 cases of intraoral cancer that only 103 patients had node involvement. Further, Ewing states that the practice of leaving nodes until clinically involved seems to be justified in view of present resources of radiation.

Duffy,[5] in 271 cases of cancer of the lip, found 210 patients, or 77.5 per cent, with no malignant nodes; and, throughout a period of observation, in 18.6 per cent there developed inflammatory nodes; and, of the 207 patients entering without nodes, 90.1 per cent did not have any nodes develop. The percentage of node involvement varies with different regions. In cancer of the tongue, in 43 per cent no nodes developed throughout; in cancer of the floor of the mouth 44.2 per cent of the patients had no nodes, and in the inframaxillary group 65.5 per cent were free of malignant nodes throughout. He feels that conservative treatment of cervical lymph glands is rational. The invaded nodes tend to inhibit growth of metastases, and irradiation assists by action on the tumor and its bed.

Crile[6] describes a collar of lymphatic glands around the neck and says that it forms an almost

Fig. 12.—Mixed tumor of the parotid.

Fig. 13.—Mixed tumor of the parotid (shown in figure 12), specimen cut in half.

impossible barrier through which cancer rarely penetrates and every barrier is easily accessible to the surgeon.

We have followed the plan of treating the infection with antibiotics, preparing the patient physiologically before operation. Whether the primary lesion of the lymph gland spread is attacked first depends on the surgeon and his experience. We have noted no particular difference in the results. In cooperation with the departments of chemosurgery and x-ray, we remove glands by block dissection in patients they have treated; and, where surgical treatment is the choice, there is no preoperative or postoperative radiation. Infected lesions respond when prepared physiologically and given antibiotics.

Extensive lesions bring up the law of diminishing returns. As to whether the extensive surgical treatment, with the pain, dysfunction, and time of survival, is worth while, a great deal depends on the surgeon's skill and judgment. The principal cause of death before present anesthesia and antibiotics was inhalation pneumonia. More extensive surgical treatment is now possible (figs. 9 to 13).

Conclusion

1. Our therapy of superficial malignant growths of the face, lip, and neck has been changed so that the local lesion is treated with chemosurgical procedures.

2. Lymph node extension and widespread local lesions are treated surgically.

3. Chemosurgical treatment accurately removes the local lesion, saves normal tissue, and does not impair the tissue remaining.

4. In a carefully controlled series of cases of the lower lip, 247 cases observed for three years with a 91.3 per cent follow-up showed successful results in 92.8 per cent and in 197 cases followed for five years with an 81 per cent follow-up there were successful results in 90 per cent. The patients lost from observation showed no recurrence when last observed.

5. Early diagnosis will be effected through education of the lay people and the dental and medical professions.

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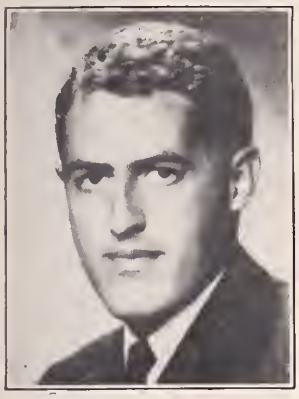
The Significance of Radioisotopes to Radiology*

By J. W. J. CARPENDER, M. D.
Chicago



J. W. J. CARPENDER

Doctor Carpender, a graduate of the Columbia University College of Physicians and Surgeons, is assistant professor of radiology and director of radiation therapy at the University of Chicago Clinics and Hospitals. He served in the United States Navy for four years, being discharged in 1946 with the rank of lieutenant commander. Following graduate work in the radiation laboratories of the University of California, Berkeley, he joined the staff of the University of Chicago in 1947.

THE application of radioisotopes to the specialty of radiology is in its infancy. Perhaps the best way to come to some conclusion concerning the significance of radioisotopes to radiology will be to review the few which have been used in therapy and diagnosis and attempt an estimate of their probable future in this medical specialty.

While a large number of artificial radioactive elements have been produced, most of them are of interest only to physicists and not to physicians or biologists. Of more than eight hundred, only a few have proved to be useful in the study of biologic processes, and, of these, two have now been established as successful agents in the treatment of disease—namely, radioactive phosphorus, P^{32}, and radioactive iodine, I^{131}. I shall discuss these two before mentioning some of the others of lesser importance and discussing the use of tracers.

P^{32}, which has a half life of 14.3 days, emits a beta particle with average energy of 0.6 MEV which penetrates about 8 mm. of tissue; it was first used by Lawrence and his co-workers[1] in the treatment of chronic leukemia in 1939. Since that time many others have shown the efficacy of this agent and the simplicity of its use. While P^{32} may be given by mouth, the method of choice is the intravenous injection of a solution of isotonic sodium monohydrogen phosphate. The intravenous route is preferable because of variable absorption when the oral route is used. Dosage in the chronic leukemias usually varies from 1 to 3 millicuries, depending upon the severity of the disease. Repetition of treatment is governed by response of the peripheral blood cell count and relief of symptoms. In cases in which symptomatic relief is obtained but a high white cell count remains, treatment with P^{32} is suspended. Frequently, x-ray therapy is needed in order to reduce an enlarged spleen or lymph nodes where these have not decreased in size under P^{32}. Overdosage must be guarded against by careful study of blood cell counts and marrow biopsy. When there is either a rapidly falling white cell count which will soon approach normal levels, with platelet deficiency, or the marrow shows low levels of cellular elements, extreme caution should be used and further therapy delayed. The presence of anemia is not in itself a contraindication to P^{32} therapy, as it frequently is due to overcrowding of the marrow by leukemic cells. A rising red cell count is to be expected in such cases in which therapy is successful. In general, multiple small doses of P^{32} are more successful than single large doses and allow better control of the disease. While there has been no evidence that this form of treatment prolongs life to any greater extent than other forms of therapy, its simplicity and the absence of radiation sickness make it the treatment of choice in chronic leukemia. As illustration, 1 case of chronic leukemia recently treated at the University of Chicago Clinics is presented.

The patient was a 26 year old white woman who was found, in 1946, to have a 38,000 white blood cell count at the time of the first postpartum visit. Within two months her count had reached 78,000, and she was started on Fowler's solution and given liver and iron. Two years before being seen at the University of Chicago Clinics, she had noted intermittent joint pains, lachrymation, and rhinitis, which continued until admission. There was occasional swelling of the fingers and tenderness of the finger tips. She felt weak and tired. Her blood cell count was reported to be normal shortly after the start of arsenical treatment, which had been continued until she was first seen by our group.

Her family and past history disclosed no pertinent information.

Physical examination was that of a fairly healthy white woman with dark skin and obvious conjunctivitis and rhinitis. Hair was abundant.

The liver and spleen were palpable at the costal margins, and small, shotty, nontender nodes were felt in the cervical axillary and inguinal regions. Most of her reflexes were slightly exaggerated. The physical examination was otherwise negative.

A blood cell count disclosed 1,000 white blood cells with 57 polymorphonuclears, 30 small lymphocytes, 11 monocytes, 1 eosinophil and 1 basophil. The hemoglobin content was 11.9 Gms., and there were 3,690,000 red cells.

A diagnosis of chronic myelogenous leukemia with arsenic poisoning was made, and all medication was stopped. As is shown in figure 1, the red blood cell count returned to normal within a few months. Soon an elevation in white cell count followed, and she then became slightly anemic. At this time we felt it wise to give P^{32} therapy and figure 1 shows the response. Her red cell count improved at the same time as the white cell count fell from its high level.

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* Read before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

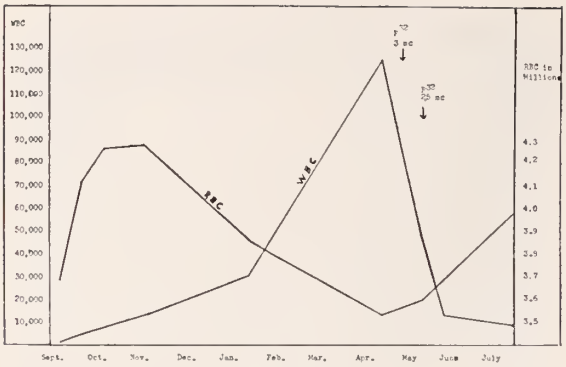

Fig. 1.—Recovery from arsenic poisoning and response to P^{32} in chronic myelogenous leukemia. At first visit patient had arsenic poisoning. Administration of arsenic was stopped. There was rapid recovery of the red cell count with slow decline as remission ended. A new remission was produced by P^{32}.

At the present time neither spleen nor liver is palpable, and the patient feels well and is leading a normal life. There were no reactions of any sort from either dose of P^{32}.

Acute leukemia, Hodgkin's disease, lymphosarcoma, and multiple myelomas, in general, have proved refractory to P^{32}, but a few of the reports are favorable. In polycythemia vera, however, P^{32} has become almost the standard treatment. Dosage is quite different from that used in chronic leukemias. Up to 6 millicuries may be given in a single treatment, but these doses are not repeated more frequently than every three months. When the red cell count is very high, phlebotomy is used to reduce the count before the effect of the phosphorus is manifest. This effect may require as long as six weeks to become evident, and if the hematocrit reading has been reduced to 45 before P^{32} is given, few phlebotomies will be needed to avoid the hazard of thrombotic phenomena and other complications of the disease in this interim.

Some authors have warned against the use of P^{32} in polycythemia vera, in the belief that it increases the incidence of leukemia, which is not an uncommon complication of this disease. One series of cases reported by Hall[2] included 4 cases of acute leukemia, but Lawrence[3] quotes a personal communication from Hall to the effect that no further cases have been seen for the past three years. No explanation for this is at present available, and no other reports have shown this complication. Lawrence[3] does not believe that the incidence of chronic leukemia is increased by this method of therapy.

The following case shows the response of a patient with polycythemia vera to P^{32} over a period of years. Attention is called to the effect on the moderately elevated white cell count which, despite a large dose of P^{32}, has not fallen below 5,000. It appears that the normal white cells in polycythemia vera are not as susceptible to P^{32} as are the red cells.

The patient was a 67 year old white man, first seen in 1944, complaining of pain in the legs on exertion and poor memory dating from an automobile accident in 1939. He had been treated by local physicians for the preceding five years for heart trouble, but to no avail. His history was otherwise negative, except that he stated that his complexion had always been ruddy, but increasingly so for the past ten years. Recently, small veins had become prominent on his nose.

Physical examination was negative, except that he showed an extremely ruddy complexion and evidence of arteriosclerosis. His blood pressure was 140/98, and his spleen not palpable.

When first seen, his red cell count was 5,800,000 with a hemoglobin content of 18.8 Gm. The hematocrit reading was 65 per cent. His white cell count and differential count were normal.

The blood cell count was fairly well controlled by phlebotomy for a year, but when it went to 6,750,000 red cells with a hematocrit reading of 70 in 1945, he was given P^{32}. The results of this treatment can be seen in figure 2. When last checked, the patient was asymptomatic.

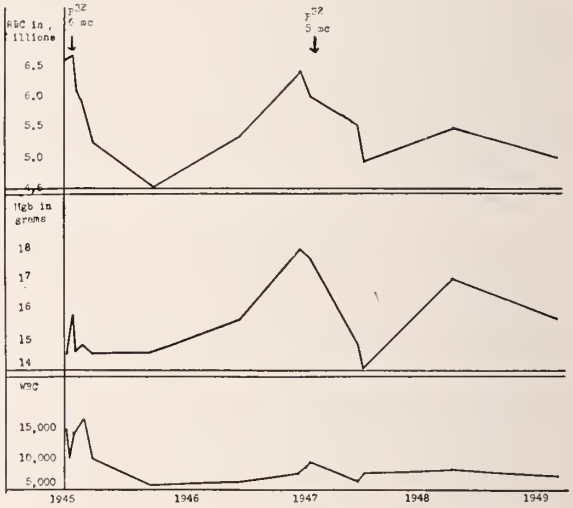

Fig. 2.—Polycythemia vera treated by P^{32}, showing two remissions of two years' duration.

Iodine[131] was first used by Hertz[4] in the study of thyroid physiology. Because it was almost selectively utilized and stored in the thyroid gland, its diagnostic and therapeutic use was soon attempted. In better than 60 per cent of thyroid carcinoma, I^{131} will fail, but in cases in which uptake occurs, some spectacular results have been obtained. A study of the pathology of the cases in which the condition does respond indicates that some form of activity simulating normal thyroid function is needed in order that the radioactive iodine will be effective. In cases in which the cells of the tumor are unable to use and store iodine, poor results can be expected. This usually is the situation in papillary adenocarcinoma. Solid alveolar carcinoma shows uptake occasionally, and follicular and alveolar carcinoma show utilization in over 50 per cent of cases. As pointed out by

Seidlin[6], when normal thyroid tissue is present at the same time as is malignant tissue, the normal tissue is in competition with the malignant tissue for the iodine. Removal of the normal tissue by surgical treatment or irradiation serves to remove this competition, and, in addition, the malignant tissue is stimulated to take over the functions of the absent thyroid, thus enhancing iodine uptake. Use of thyroid-stimulating hormone often increases this effect.

External irradiation is well established as a useful agent in hyperthyroidism when for some reason surgical treatment is contraindicated, but the results of modern surgical procedures are so predictable and permanent and satisfactory that surgical treatment must be recognized as the method of choice whenever it can be employed safely. The status of irradiation by means of I^{131} is by no means as clear, because not enough time has yet elapsed to allow adequate assaying of the risk of late neoplasm resulting from such irradiation. Because of this potential risk, it is well to employ I^{131} only in two classes of patients: (1) patients who cannot or will not submit to operation or (2) patients over 60 years of age in whom the normal life expectancy is so low that the danger of late neoplastic degeneration is slight. It is entirely possible that I^{131} will become the common method of treating Graves' disease in future years.

The dosimetry of I^{131}, which has a half life of 8.0 days, is complicated by a number of factors. In the first place, it emits both beta and gamma radiation, the beta particles having an average energy of 205 kilovolts, and the gamma photons of 80 and 367 kilovolts. Most of the effect is derived from the beta particles which penetrate a maximum of 2.2 mm. of tissue, but in calculating dosage, the gamma photons cannot be neglected. Secondly, estimation of thyroid size or size of metastases is bound to be inaccurate, but any expression of dosage in equivalent roentgens depends upon the amount of tissue irradiated. Thirdly, the amount of iodine taken up by the tissue and the rate of release from this tissue also controls dosage. For detailed discussion of dosage problems the reader is referred to the publication of Quimby.[6] A simplified formula for the total dose in equivalent roentgens is as follows:

$$\text{er} = \frac{\text{administered} \times \text{uptake}\%}{\text{Gm. thyroid}} \times \frac{\text{biological half life}}{8} \times 160$$

This formula gives a dose in an average patient of slightly over 3,000 equivalent roentgens. In carcinoma of the thyroid, as in Graves' disease, actual administration of iodine^{131} is governed by the response of the patient. After a tracer dose of 1 to 2 millicuries has shown, by means of Geiger counter survey over the lesion, that a carcinoma or its metastases will utilize iodine, doses of from 50 to 100 millicuries are given at bimonthly intervals until there is no further uptake. The use of thyroidectomy and thyroid-stimulating hormone should not be forgotten where uptake is low.

In Graves' disease, fractionated dosage is favored, about 2 to 4 millicuries being given every six weeks to a total of 10 to 12 millicuries, depending on symptoms and the basal metabolism rate. The iodine is given by mouth as an aqueous solution of inorganic radio-iodine containing no normal iodine. Complications are few, but serious. In Graves' disease, overdosage may produce thyroid storm immediately and myxedema later. In carcinoma, the very large doses which are used appear to have damaged the bone marrow in some patients.

Clark[7] recently has shown that a study of the ratio of protein-bound iodine to total plasma iodine gives an excellent index of thyroid activity. In a large series of cases of hypothyroid disease, hyperthyroid disease, carcinoma, the euthyroid state, and unrelated diseases, he has found almost no overlap in the various ranges of what he has termed the conversion ratio. He believes that the determination of this conversion ratio may prove to be useful in differential diagnosis.

Radiosodium, radioarsenic, manganese, and gold have been used in the treatment of diseases of the hematopoietic and lymphatic systems. Their effect is much like total body irradiation, and they have the disadvantage, as compared with P^{32}, of irradiating structures where no radiation is desired. Also, overdosage is more difficult to prevent than is the case with total body x-ray. Diagnostically, sodium holds promise, for in tracer amounts it has been found useful in the diagnosis of peripheral vascular disease, as shown by Smith and Quimby.[8]

Radioactive cobalt, Co^{60}, may be of considerable importance. It is doubted that it will ever replace radium, because of its relatively short half life, of 5.3 years, but in some instances it could be most useful. It emits an almost monochromatic gamma radiation, which is a little stronger than that of the average of radium, and a very weak beta particle, so that filtration is not a problem. For needles and certain intracavitary applicators now in process of design, it may be ideal. Even more important could be its use in large sources comparable to the so-called radium bombs. Such installations with sources as great as 400 curies are planned.

It seems hardly necessary to emphasize to radiologists the problems connected with handling radioisotopes and in disposal of waste material, but some mention of specific methods may be of interest. In the case of P^{32}, when a liquid is handled in a syringe, rubber gloves should be worn to protect the hands from contamination and a jacket of lucite placed around the syringe to absorb the beta particles penetrating the wall. After use, the syringe and needles should be stored until decay has reduced the radiation to a point where the instruments may safely be cleaned, sterilized, and reused. In all isotope work, an instrument should be reserved for a particular material and never used for another. This is espe-

cially true where delicate biologic tracer work is being done.

Iodine[131] should be stored in a lead container, and, where any sizable quantity is on hand, the individual doses should be removed by remote control, with the operator well protected by lead and distance. Individual doses are carried to the patient in paper cups in a lead box. The patient removes the cup and handles it himself. After use, the cup is disposed of with other active waste. Where urine and feces are to be collected, the patient does this himself, thus reducing exposure of those who routinely work with the isotope. These materials are allowed to decay until the radiation is minimal and then are disposed of in the sewer, where normal dilution eliminates danger. Other isotopes are handled in a similar fashion, with protection depending on the quantity and quality of radiation.

A large number of isotopes other than those mentioned have been used as tracer elements in the study of various vital processes. There is little difficulty in handling the usual tracer quantities from a standpoint of radiation hazard other than careless contamination, but there has been noted a tendency to exceed safe dosage levels by workers who, despite even elementary knowledge of radiation hazards and effects, have been allowed to undertake such studies. That this ever occurs is even more unfortunate when one considers the excellent article by Marinelli,[9] where dosage calculations are given in detail and tables show safe tracer amounts for many different isotopes. As radiologists, we are only too well aware of the dangers of ionizing radiations, and cannot accept the excuse often given, "I use a large dose because it is so hard to measure the small amounts in my samples." This seems poor justification for endangering the health of a patient and can best be explained on the grounds of ignorance.

The problem of who shall be in charge of an isotope program has arisen many times in the past and will arise with increasing frequency in the future. The answer is an entirely logical one and is always "the person or persons best suited to handle the particular situation." The solution may be a group or a number of groups and may not necessarily include the radiologist, especially in larger institutions, where the diseases to be treated may be far separated from the field of the radiation therapist, or the problems in diagnosis lie in subjects not ordinarily studied in roentgenology. This becomes less true where the staff is smaller and perhaps part time and where the radiologist, by virtue of his special knowledge and training, may be the one best suited to safeguard the interests of patients and personnel. The problem is bound to vary from place to place, and no set rules can be laid down. Because of his knowledge of radiation hazards and familiarity with methods of protection, the radiologist is almost certain to be called in consultation. It must be emphasized that just as therapeutic radiology and diagnostic roentgenology have become specialties in themselves, the field of isotope work may become a subspecialty of therapeutic radiology. Certainly, if the amount of specialized knowledge of mathematics and physics required for proper handling of isotopes continues to increase in the future as it has in the past ten years, it will be beyond the power of a single individual to practice in both fields and do justice to either.

At our own institution the situation is this: We have scores of men and women using radioisotopes in dozens of different biologic and nonbiologic applications. Whereas I am primarily a clinical radiologist specializing in irradiation therapy, responsibility for our health hazards is a full time job in which I have neither the time nor the inclination to engage. I am concerned with it, however, in an advisory capacity, and presently will have considerable administrative responsibility in connection with it, so I have to try to keep abreast of the field in order to advise and administer. The matter of personal prestige counts for nothing in our set-up, and I am sure should not obtrude in any organization.

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The Physician and Mental Health*

By REYNOLD A. JENSEN, M. D.
Minneapois

R. A. JENSEN

Doctor Jensen, a graduate of the University of Minnesota Medical School served as a director of youth activities in Milwaukee before obtaining his M.D. degree. After internship and three years of graduate training in psychiatry, he joined the faculty of the University of Minnesota in 1938. He is now an associate professor of pediatrics and psychiatry and is in charge of the child psychiatry program at that institution.

THE character of medical practice has changed during the past 50 years. Research has given us more effective tools of diagnosis and treatment. Prevention has become the ultimate goal toward which we strive. A tremendous shift in our population age has occurred. Change in the organization and structure of society resulting from technologic advances has created a condition of flux such as we have never experienced. The attitude of the average individual toward health problems has also changed. In this process old problems have been solved, only to be replaced by others. Many important health problems demand our consideration—cancer, cardiovascular disorders, poliomyelitis, geriatrics, to name only a few. However, there is no question that the number 1 health problem facing us today is the problem of mental health.

Permit me to appeal to your imagination. Imagine a population equal to that of the largest city in our country today awakening tomorrow morning with each member afflicted with serious mental illness. One out of every four has become schizophrenic. One out of ten has become a manic-depressive. Another 10 per cent of the population are suffering from the psychosis of senility. Five per cent are paretic, with the remainder suffering from paranoia and other types of frank mental illnesses. Every individual in that population suddenly requires immediate psychiatric services! Such is the problem we face today, with approximately 8,000,000 people currently suffering from some type of serious mental illness.

To meet this situation, what is available in the way of psychiatric services? Approximately 4,000 psychiatrists, 1 to each 2,000 patients, which is totally inadequate. Approximately 600,000 hospital beds, 1 to each 13 patients, are available, which means that, for every patient occupying a hospital bed, there are a dozen not receiving such care.

Let us look at the situation another way. Appealing to your imagination again, consider a group equivalent to the combined populations of Chicago, Philadelphia, Detroit, and Los Angeles who are suffering from emotional disturbances which have not yet reached the obvious stage requiring intensive psychiatric attention. In this second group would be a million or more children with behavior problems, more than a quarter of a million youthful delinquents, and several million adults who are having marital problems or problems of work adjustment, or are shrinking from imaginary evils, dreaming of impossible conquests, preying upon the weaknesses of their neighbors, or drinking themselves into an early grave. Among the entire group are many whose emotional troubles are manifested by somatic complaints. Any individual psychiatrist faced all at once with his assigned quota from these two groups —those seriously ill and those less disturbed— would be forgiven if he quietly slipped away from his office and joined the multitude in disguise. In a short time no disguise would be necessary.

In anticipation of meeting adequately the pressing problems of mental health, much emphasis has been given to the training of personnel. The need is expressed for 20,000 psychiatrists, 40,000 psychiatrically trained social workers, and 20,000 clinical psychologists and for more clinical facilities. There can be no question that these are essential, and ways and means must be found to supply them.

However, if they could presently be available it is questionable whether they, in and of themselves, could accomplish the task assigned to them!

As with every medical problem, no satisfactory solution can ever be found, particularly if prevention is to be accomplished, unless each of us joins with the other in common effort toward its resolution.

Up to the present time little emphasis has been given to the important contribution *all* physicians can make, if they will, in this area.

Ziskind[1] has suggested "The time may now be ripe to give life and vital energy to some parts of the mental hygiene program that have been relatively neglected." He further mentions "a number of practical aspects which suggest that medical practice has potentialities for being the richest field yet to be subjected to mental hygiene efforts . . . First, there is the tremendous number of individuals involved. One-third to one-half of all patients seen in medical practice are said to owe their symptoms to psychological conflict rather than physical disease . . . A second great advantage is that relatively few new resources are required—this is a field in which it is

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

not necessary to stimulate people to do something about it. Here are the people actually seeking help." The third advantage is that "the psychological problems involved present themselves to the medical profession at an early stage." A fourth, which is stressed is "the fact that the medical profession is a great educational force." Hence, "the properly oriented physician should prove to be one of the most potent factors in the dissemination of mental hygiene precepts." The final advantage is that "medical practice could be a great testing ground for psychiatric concepts—taking a psychiatric program out of the cloistered chambers of the specialist and exposing it to the practical experience of the general physician, should have a very salutory effect on psychiatric theory."

It is my hope to stimulate your interest and to define a few areas in which we can all work toward preventing the development of maladjustment problems and toward treating patients with early symptoms of them.

First, however, let us define our terms, "mental health" and "mental hygiene," which are often used interchangeably. As there is a real distinction between them, it is well for us to be cognizant of it that we might use the terms correctly.

Mental health is the state or condition of mental well being. It simply means the ability to get along satisfactorily with one's self and others. It implies the ability to meet "difference" not as something to be feared but as something which can stimulate further individual growth. It implies the capacity to accept and discharge to society responsibility commensurate with natural endowment, training, and experience.

Mental hygiene, on the other hand, is not a state or condition. It is a process, the process whereby we achieve and maintain the state of mental health. More than a century ago the German psychiatrist, Ernest von Feuchtersleben[2] defined it as "the means by which the health of the mind is preserved." This definition implies a willingness to understand our own basic needs as well as others and to initiate and promote a program of action which will result in better mental health.

We all have an idea of what we mean by a healthy body or what the dentist means by a healthy mouth. What do we mean by a healthy personality? This definition, given me recently by one of my colleagues, is that of a "flexible person," but it applies full well to an individual whose personality is in balance—who is in good mental health. Here it is:

"The flexible person is one who respects himself but has no conceit, who has been guided by principle but who has not been the slave of dogma, who has had steadiness of purpose without being hypnotized by an inimitable goal, who has bent his energies to making the grade rather than getting to the top first, who has tolerated his weakness while employing his strengths, who has respected his neighbors as well as has had pride in himself."[3]

It is seldom that we meet such a well balanced person, but neither do we often meet an individual in perfect physical health. If there were more of *them*, there would be *fewer* of us. But it does give us an ideal—a goal toward which to strive.

We physicians are aware that there are always two phases to every medical problem. One is to meet the needs of the moment, the other is to anticipate the developments of the future, namely, prevention. In what areas can we, as physicians, work in preventing the development of mental and emotional disorders?

Elementary though it may be, it is well to remind ourselves that most living occurs in relation to others. When our relationships with others are in good order, we function more satisfactorily than when the opposite prevails. We are also aware that our current abilities to handle our immediate interpersonal relationships depend primarily upon the manner in which we have managed these relationships in previous experiences. In many instances our manner of meeting current problems is a reflection of the way in which we, as children, learned to behave.

We are only now beginning to understand how devastating parental anxieties, whatever their source, are to the child's peace of mind. Many factors may be responsible for this state of affairs: the radio, magazines, newspapers and books on child rearing may contribute to the parent's feeling of inadequacy. These feelings are often reinforced by the conflicting opinions of "experts" regarding basic principles of child rearing. Perhaps our own lack of understanding of this problem may also be important. It is safe to assume that parental insecurity is far more common in our culture than has been generally recognized. Huschka and McKnight[4], working in a well-baby clinic, found all but 5 mothers out of 57 "had complaints in regard to their babies." In 3 of the remaining 5, maternal anxieties "were interfering with emotional development of the child." Langford[5] reports the incident of a fourth year medical student who spent two hours taking a history and examining a child brought to the clinic because of "nervousness." Unable to discover the cause he appealed to the instructor, who, through a single question, found the mother was suffering from a paranoid psychosis. He adds the mother "who brings in her child for a physical disorder is often equally as revealing of the concerns, worries and preoccupations which have emotional significance for her and for the child." Further, the mother may carry over into her relationships with her child "unresolved conflicts in her relationship with her own parents." The recognition of parental insecurity as it relates to the problems of children and helping parents deal with it, presents many opportunities for promoting mental health.

For this reason, and because of my own particular interest in the field of child psychiatry, I should like to consider the importance of infancy and childhood indicating several areas in which all of us, irrespective of our special interest, might find opportunities to engage in preventive work.

Recognizing that wholesome parental attitudes are of primary importance in the child's growth and development, an excellent opportunity for counselling is offered every physician who does premarital physical examinations. Practically every young person contemplating marriage has questions. Given a little encouragement, he *will* seek the help of his physician. This can be our cue to offer information and counsel which may not only smooth the way for a more satisfactory marriage relationship but also for children who may later join the family.

A second excellent opportunity to which a growing number of physicians are giving increasing attention presents itself during the pregnancy period, particularly during the first pregnancy. Here is the physician's opportunity to counsel with prospective mother and father not only about the physical needs of their child but also about the basic principles of growth and development, the child's immediate and continuing need for affection, the importance of parental understanding of what they can expect of their growing child and his behavior at any one stage of development, the desirability of preventing undue shocks and fears during early life, and the comparative significance of some of the factors in early training often overstressed. During this period an excellent opportunity presents itself for anticipating the anxiousness of parents and preparing for it. Such preparation may well make the handling of later difficulties easier for both physician and parent.

Immediately following birth an excellent opportunity is offered the physician to allay both maternal and paternal concern. Their most pressing question at this time is "Is he all right?" Fortunately, most newborns are "all right," but occasionally a defective child comes along. A forthright consideration of the problem at this time can mean much toward promoting an attitude of mental balance. From our experience over the past years, we have encountered countless numbers of mothers with defective children who have told us "I knew from the very beginning something was wrong. Why didn't the doctor talk with us?" Procrastination or delay at this time may mean serious adjustment problems later. Better that we consider fully and completely the situation with the parents early. And above all, consider the problem jointly with *both* parents!

One of the greatest opportunities for promoting good mental health comes during the period of infancy and early childhood. Spock[6] has reminded us that many adjustment problems develop through unskillful handling of the typical everyday experiences of childhood, such as feeding, weaning, sleeping, thumbsucking, toilet training, sibling rivalry, and the attendant frustrations incidental to development. Aldrich[7] and Tenney[8] have given us excellent presentations on basic principles inherent in development of good parent-child relationships. When these relationships are established and maintained on an easy, friendly basis, one of the chief sources of emotional tension in children is eliminated.

Today many progressive physicians are giving serious thought to ways and means of promoting the establishment of this important relationship early in life. Providing the mother an opportunity to assume some responsibility for her child during hospital stay following delivery gives promise for helping mother and child to get started right. The avoidance of rigid schedules of daily routine is likewise easing many anxious moments for both parent and child. Knowledge of what to expect of a child at any given age in the way of speech ability, play interests, and responsibility he can assume is of major importance in avoiding adjustment problems.

Every physician serves a good many children handicapped by physical or mental deficiencies. With regard to the former, it is not uncommon for the physically handicapped child to compensate for his difficulty by excessive demands for attention and sympathy. It singles him out as a person who has a special claim on life. During treatment of the physical disorder, the understanding physician can assist the child to make valuable emotional adjustments which may enable him to manage his living more successfully. If the physical disability cannot be successfully treated, much can be done to help the child find adequate compensation in other fields. In so doing, it may be essential to give help to parents who are prone to be either overprotective, overanxious, or even resentful of the child's handicaps. Retraining the parents is often the more important and may be more complicated.

The problem of helping parents with children who are mentally handicapped is a difficult one but one which carries with it many opportunities for promoting mental health. The essential core of the problem is the recognition of the parental anxiety which usually prevails in such circumstances. Too often the parents are disappointed by our lack of fully appreciating their need for help to substantiate their feelings about the child and to find a satisfactory solution to it. Helping parents evaluate the child's developmental status, offering a possible explanation for the deficiency, and prognosis as well as helping them plan for the future will ameliorate many of their tensions. In the process, the stability of the home may be preserved.

Failure is a serious threat to the successful adjustment of the school child. As a result many children may become "behavior problems" while others will attempt to compensate by falling ill. Not long ago a lad of 14 years came to our clinic with complaints of headache and gastrointestinal distress, a combination which can have serious implications. Thorough physical studies, directed primarily to the central nervous system, were entirely noncontributory. Psychologic study revealed the presence of a severe reading disability, which caused him to fail in his first year in high school. His superior intelligence had enabled him to master grade school, but in high school competition was too keen and he was failing. Appreciation of the basis for his trouble

made possible a satisfactory solution to his school work, with prompt disappearance of symptoms. It is estimated that approximately 10 per cent of the children in our schools are unable to read satisfactorily, due either to poor teaching methods or to a true learning disability. Preston[9] has clearly pointed out the serious threat which reading failure has to the child's security. Other causes for school failure are related to intellectual capacity, a minor physical disorder usually unrecognized, poor preparation, or the presence of excessive emotional tension. Of the many sources for emotional tension, excessive demands of the parent are perhaps the most common.

Every child should be encouraged to succeed in those achievements which are socially acceptable and in those in which he himself wants to succeed, but no child should be forced beyond his capacity nor be expected to prepare for a life work contrary to his own preference. Parents, consulting the physician because their child is not doing well in school, can be helped.

The physician's handling of children may often precipitate difficulties, a fact many of us overlook or may disregard because of our busy schedules. The reassuring "now it isn't going to hurt" when we immunize a child or draw a blood sample may work *once*. The probabilities are that it will not work again. Perhaps it hasn't, by our standards, caused much actual pain or discomfort but to the tense child, anxious and fearful of the unknown, it is magnified a thousandfold. Pearson[10], Levy[11], and Jensen[12] have pointed out the adjustment difficulties which may often follow surgical procedures for which the child had not fully understood the necessity or been adequately prepared. Far better to make sure the child is prepared for whatever we do and why, encouraging an attitude of trust and confidence rather than instilling an attitude of fear which may later result in trouble. Kanner[13] has dealt at length with this phase of child management. Parental cooperation and understanding are of vital importance in this area also.

There is an increasing trend on the part of many childless couples to adopt children. The physician's understanding of the real needs and motives of such individuals can increase his effectiveness in making easier later adjustments for both the child and his adoptive parents. No longer is it enough to say to Mrs. X, "What you should do is to adopt a child." In this regard many future adjustment problems could be avoided if we physicians would wholeheartedly cooperate with the legally licensed adoptive agencies which have been set up to safeguard the rights of both the child and society.

Only a few of the more common situations in which we physicians can be of help in preventing serious mental health problems in children have been mentioned. Many more could be considered. If I could emphasize but one point in this discussion, it would be the need for finding the root of the child's problem. In most instances it can be found in the failure of parents to anticipate or to provide adequately for some need of their children. Most parents sense their failure and seek our help.

Our opportunity rests in our willingness to accept their problems and work with them in an objective, noncritical way to define the sources of the difficulty and to find a solution. Most parents can be helped to deal more effectively with their children through such a relationship with us.

What of the other areas? It is well recognized that many illnesses affecting man cannot be accounted for by physical factors alone. Earlier it was suggested that from one-third to one-half of our patients owe their symptoms to psychologic conflict rather than physical disease. Painstaking and persistent research has firmly established that a close relationship exists between tension states in the individual and bodily function. As a result, we hear much about psychosomatic medicine. In essence, it simply means a point of view which accepts the fact that both physical and mental factors are important in illness, that equal consideration be given to the relative importance of each in every illness, and that, in addition to physical studies, psychologic study is essential in each case.

Gillespie[14] has suggested three ways in which emotional factors may be important in illness: They may cause illness, as in conversion hysteria or the acute anxiety states. They may precipitate attacks of illness such as asthma; or they may be a sustaining factor as in hypertension.

Recognition and acceptance of the mind-body relationship opens many new avenues for us all to understand the process of illness and should assist us in its better management. Here is an excellent opportunity to promote better mental health by the avoidance of a mistake in diagnosis.

The businessman's ulcer may flare up because of a drop in the stock market. The working man's asthma may get worse when his wife is having a child and he can find no place to live. Obviously we can do nothing about either the stock market or the current housing shortage, but we can help our patients to understand the possible relationship between stress-producing situations and their illnesses and to find more satisfactory solutions to such problems. English[15] suggests, "we must not be content with what we see on the surface."

In no way does this suggest that every physician should become a psychiatrist. It does imply, however, our willingness to recognize in each patient the influences of emotional stress and strain on the economy of the bodily processes and consider these along with every other factor which may be important. To do so should help us avoid much dissatisfaction and disappointment, as must have occurred among the patients recently studied by Bennett[16]. In a group of 150 patients, he found they had been subjected to 496 medical treatments, 244 surgical procedures, and 71 miscellaneous treatments before the basis of their difficulty was properly diagnosed!

There are many physically handicapped individuals in our communities who, through rehabilitation agencies, can be helped to become productive members of society. What greater satisfaction is there for most of us than that of being self-sufficient! In my own state of Minnesota, during the past year nearly 600 men and women were enabled, through rehabilitation procedures and special training, to find employment. An average investment of $138 per individual enabled the group to earn annually more than $1,000,000. Is this not an area where we as physicians can be of assistance in promoting mental health?

As the average age of our population increases, the problems of the aging and of chronic disease require increasing attention. We are learning that much more can be done for these people than was formerly thought possible in the way of physical medicine. Of equal importance is the help that can be given toward making a satisfactory emotional adjustment.

Acceptance of the limitations imposed by physical impairment or retirement with decreased financial income, diminution or change of pleasurable activities, or the loss of close friends or relatives requires consideration if those so affected are to realize maximum satisfaction and pleasure with their new lot. There may not be much to offer a patient suffering from terminal cancer in the way of medical treatment, but one can be mindful of the great comfort an occasional visit from the physician or from the visiting nurse can mean to these patients. Likewise, the support which can accrue from such procedure to the families of such patients can earn for us their everlasting gratitude. Some there are who may be inclined to skepticism at such a suggestion, but let us remind ourselves of Strecker's[17] suggestion, "it it not an overstatement to say that fully fifty per cent of the problems of the acute stages of an illness and seventy-five per cent of the difficulties of convalescence have their primary origin not in the body but in the mind of the patient."

The need for our help is greatest at the beginning and at the end of life. It is in the closing chapter of life that the wise, understanding physician can make a significant contribution to mental health. Let us not continue to underestimate the effectiveness of faith, confidence, sympathy, of the patient's conviction that something is being done for him, better still that he is being helped to do something for himself.

The nineteenth century German philosopher Nietzsche, who had something to say about most of the professions, made some very acute observations on the dual role of physicians as body doctors and "soul doctors." "The highest mental development of a physician has not been attained when he knows the latest and best methods and is skilled in performing them," says Nietzsche. "He must possess the facility of speech which suits itself to each personality and is able to draw the heart out of his breast; a manliness which dispels at a glance despondency (the worm which feeds on every patient), a diplomatic keenness capable of mediating between those who need happiness for their cure and such who in their complete health must and can spread happiness; the cunning of a detective or an advocate who understands the secrets of a soul without divulging them. In short, a physician now requires a grasp of all the dexterity and intricacies of all other professional classes. Equipped in this way he is able to be a benefactor to the whole of society."

If this were true at the time Nietzsche lived, it is equally true today, for we today have the advantage of the lessons accruing from the scientific study of mind-body relationships. We have available a better understanding of the dynamics of human behavior and the many defense mechanisms which we all employ in making our individual adjustment to the everyday world. In addition, we have improved our own understanding of our most important working tool, speech. Hayakawa[18] has suggested that many of the world's ills result from the lack of basic understanding of language. He states "to cure these ills we must first go to work on ourselves. An important beginning step is to understand how language works, what we are doing when we open these irresponsible mouths of ours, and what it is that happens, or should happen, when we listen or read." An appreciation of our role as an educator can be a tremendous force for promoting mental health. Unlimited possibilities present themselves to educate our patients young and old into logical thinking about body functions. In so doing we can allay many fears and misinformation.

With living becoming more complex, it becomes increasingly essential that we make use of and work in cooperation with all the resources of our communities, social service agencies, youth groups, rehabilitation centers, school and community councils, curative workshops, and churches to mention only a few. Many of our patients and their families might conceivably be handled more successfully by referral to such agencies who, working with us, can help us and them.

Likewise, we can all encourage our several professional societies to give increasing emphasis to mental health subjects and to promote postgraduate courses in this important area.

During recent years, the United States Public Health Service has supported a vigorous mental health program. As a result, more thought is being given to this important health problem. Interest is developing in many areas. In my own state a tremendously ambitious mental health program is under way. Other states are studying the problem. All of this is encouraging and merits our support.

However, of greater importance is what we do in our everyday contacts with our patients, young and old, to help them more successfully manage the tensions of everyday living. A new reorientation can effect change in the direction of better mental health for us all.

Blain[19] has stressed the point in this way.

"Our attention is traditionally focused on the six per cent who are sick. It is the ninety-four per cent

who are well who are the most important. Mental health is more important than mental disease. Viewed without sentiment, healthy people are more important than sick people. There are more of them. They do their share of the world's work, produce enough in excess of their own needs to provide for children and the aged; and they care for the sick. It is in changing sick people into healthy people, and in keeping the healthy from getting sick, that medical science finds the chief reason for existence."

Summary

Mental health is the number 1 health problem today. While the need for more trained specialists is essential, every physician has a significant role in its resolution. When each of us is fully cognizant of the importance of emotional tension in each patient we see, when we will evaluate it along with all other factors in our diagnosis and treatment, and when we will develop our own skills in this area, this problem will be nearer its solution.

Each of us can be helpful in the following ways, through premarital counseling; psychologic preparation of mother and father for arrival of members of the family; recognition of psychologic influences in the physically and mentally handicapped, school failures, and surgical procedures particularly as they pertain to children; counseling on adoptions; a willingness to consider emotional factors in illness to insure proper diagnosis and treatment methods; an awareness of psychologic factors in the rehabilitation of patients; being mindful of the many adjustments attendant to old age and its problems; an increased awareness of how we can best use our most important tool, our speech; and a willingness to join in cooperative effort with all who are working in the interest of the general welfare of people.

Ours is a challenging opportunity and singular responsibility!

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THE AMERICAN CONGRESS OF PHYSICAL MEDICINE ANNOUNCES CONVENTION DATES

The American Congress of Physical Medicine will hold its twenty-eighth annual scientific and clinical session August 28–September 1, 1950, inclusive, at the Hotel Statler, Boston, Massachusetts. Scientific and clinical sessions will be given on all days. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction seminars will be held August 28–31. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

THE MEDICAL FORUM

COUNCIL CHANGES WPS NAME TO "BLUE SHIELD" AGENCY

Actuary Hired to Study Prepaid Plans

Madison, June 4.—The Council of the State Medical Society has employed Mr. Carl A. Tiffany, Chicago, as a consulting actuary to conduct detailed studies of both the Blue Shield Agency (Wisconsin Physicians Service) and the Wisconsin Plan of prepaid health insurance.

Will Start in June

Mr. Tiffany, a member of the consulting actuary firm of Thomas and Tiffany, will analyze the relation of the present premium structures of both plans to the fee schedule for benefits. He will begin these studies sometime in June.

Mr. Tiffany has a master's degree in actuarial science from the University of Iowa and worked with the Illinois and Iowa insurance departments before joining the Chicago firm. He has had experience with both recognized commercial companies and non-profit insurance plans.

Doctors Urged to Return Income Survey Sheets

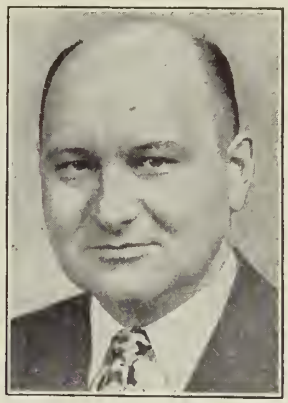
Chicago, May 22.—Physicians, especially younger doctors and those with small practices, are urged to send in the questionnaires they received a few weeks ago from the U. S. Department of Commerce.

About 100,000 white questionnaires were sent by the department to physicians all over the country in an effort to survey physician's incomes.

The survey is being conducted in cooperation with and has the support of the American Medical Association.

Dr. George F. Lull, secretary and general manager of the AMA, reports that the response to date has been "very good," but that every possible effort should be made to get all doctors who received one to send in the questionnaire.

Authorize Variety of Contracts to Increase Coverage in State



DR. E. M. DESSLOCH

Madison, June 4.—The Council of the State Medical Society of Wisconsin has authorized significant changes in Wisconsin Physicians Service (WPS) contracts which will increase the plan's ability to offer medical-surgical insurance coverage to the people of the state.

At its June meeting, the Council reviewed the progress of the plan since 1946 and approved recommendations made by the WPS directing board under the chairmanship of Dr. E. M. Dessloch, Prairie du Chien.

The Council took the following action:

1. Changed the name of Wisconsin Physicians Service to "The Blue Shield Agency of the State Medical Society of Wisconsin."
2. Established a basic surgical and maternity group contract without "extras" such as anesthesia, x-ray and medical benefits.
3. Okayed the development of riders to the basic contract to permit the addition of one or more "extra" benefits as the subscribers desire.
4. Authorized the development of a "cost-plus service contract," to be offered only to groups in specially controlled situations.
5. Granted WPS permission to write group contracts for periods up to one year in certain situations where group coverage is offered as part of a one-year bargaining agreement between employer and employee.

Changing the name of WPS to "The Blue Shield Agency" of the state medical society will help to eliminate the confusion in the minds of both physicians and public concerning the plan owned and operated by the medical society

(Continued on page 502)

Brookings Surveys Specialties in State

Madison, June 5.—A statistical survey of specialty practice in Wisconsin is being conducted by the Brookings Institution of Washington, D. C., as part of a comprehensive fact-finding study of all private and public medical care programs and facilities.

The State Medical Society, which is cooperating fully in the survey, has sent questionnaires to each county medical society requesting complete information on the number of members in full-time specialty work or who are full-time in administration, public health, teaching, industrial practice or other fields.

County society secretaries and individual non-members are urged to give prompt consideration to the completion of the questionnaires and their early return to the State Medical Society office.

Separate letters covering these same fields have been sent to all non-members of the society.

The Brookings Institution has a national reputation as an objective fact-finder, and the study is expected to have a great influence on the trend of thinking regarding health needs of the nation.

BLUE CROSS PRESIDENT B. E. MILLER, Madison, (second from right) receives an award from the Milwaukee Aerie of Elks for outstanding service rendered to the people of Wisconsin as head of the Blue Cross Hospital insurance plan. Looking on are Past Presidents Geo. P. Ettenhelm (left) and J. G. Norby, Milwaukee.

Blue Cross Reports on Progress in Its Tenth Year of Service

April 25.—New members obtained during 1949 brought the total enrollment for the year to 736,680 for Blue Cross and 391,269 for Blue Shield, it was announced recently by B. E. Miller, Madison, president of Associated Hospital Service, Inc. (Blue Cross), the hospital-sponsored insurance plan.

Since the end of 1949, the addition of new members makes the total enrollment in Blue Cross approximately 750,000 members, and over 400,000 in Blue Shield.

Although group enrollment makes up the largest part of the membership in Blue Cross—Blue Shield, there are in excess of 55,000 non-group members who pay their subscription fees directly to Blue Cross.

Nearly 6,500 Blue Cross and Blue Shield groups in Wisconsin pay their health insurance premiums by deduction from their pay checks. Mr. Miller also reported that 22% of the employers in such groups are helping partially or totally in paying for their employees' membership.

During 1949, Blue Cross paid more than $5,400,000 to hospitals for the care of 95,000 members. Since Blue Cross was established in 1940, it has paid out over 21 million dollars in hospital bills for the care of 425,000 of its members. In 1949 Blue Cross paid out slightly better than 93¢ of each dollar received for members' care, as against nearly 84½¢ for 1948.

This is the result of two factors More people were going to hospitals for treatment, and the cost of treatment in 1949 was higher than in the preceding year. Blue Cross reports, however, that people are staying in hospitals a shorter time than they did in 1948, thus reflecting the steady increase in the quality of hospital and medical care.

For all cases paid in 1949 for hospital care, the report showed that 53% required surgery, while 31% were primarily medical and non-surgical cases, and 15% were maternity cases.

Women are more likely to be entering a hospital than men, the experience of Blue Cross clearly indicates. The 1949 report shows that of all bed patient cases, 22% were men, 25% were children, and 52% were women.

Mr. Miller said that there are now more than 37,000,000 Americans in Blue Cross and over 14,000,000 in Blue Shield surgical-medical plans.

AMA TO START AD PROGRAM SOON

Chicago, May 29.—A nationwide advertising program covering newspapers, magazines and radio has been given final approval by the Board of Trustees of the American Medical Association.

The advertising program is scheduled for October and will advance the cause of voluntary health insurance and emphasize medicine's leadership in maintaining the American system and combating socialism.

Almost $1,100,000 will be spent on the program, a large share of which will go to newspaper advertising.

Ask M. D.s to Aid in College Health Study

Chicago, May 25.—A nationwide survey of university and college health services for the year 1949–50, including student prepayment health insurance plans, is being conducted by the American Medical Association.

The purpose is to determine what health services are being rendered by the college directly or by community physicians and hospitals, and how these services are being financed.

Twenty-five Wisconsin universities or colleges are included in the survey. They are:

Alverno College, Milwaukee
Beloit College, Beloit
Carroll College, Waukesha
Edgewood College, Madison
Lawrence College, Appleton
Marquette University, Milwaukee
Milton College, Milton
Milwaukee–Downer College, Milwaukee
Mission House College and Theological Seminary, Plymouth
Mount Mary College, Milwaukee
Northland College, Ashland
Northwestern College, Watertown
Ripon College, Ripon
St. Francis College, Burlington
St. Norbert College, West DePere
State College, Superior
State Teachers Colleges at
  Eau Claire
  La Crosse
  Milwaukee
  Oshkosh
  Platteville
  River Falls
  Whitewater
Stout Institute, Menomonie
University of Wisconsin, Madison

The full cooperation of physicians in college communities and those who serve as directors of college health services is needed in this important survey, says Dr. Frank Dickinson, director of the AMA bureau of medical economics.

Rep. Glenn Davis Warns of "Strait-Jacket" Plans

Madison, June 1. Master planners in Washington are seeking to "slip the noose of governmental controls over our heads" by means of three legislative proposals that would socialize industry, farming and medical care, charged Rep. Glenn R. Davis, Waukesha, in a recent reprint of his extended remarks in the House of Representatives last March.

"America is being spent and planned into socialism," Mr. Davis warned. Citing the current yearly federal deficit rate of $5 billion, Mr. Davis said, "What attitude should we take toward this immoral policy of passing on the financial responsibility of this generation to succeeding generations of Americans?"

Three current pieces of legislation were described by Mr. Davis as typical of the "sordid" and "dangerous" planning of the "Ewing – Keyserling – Brannan-Altmeyer cabal:"

One—The Spence bill (H.R. 2756, Economic Stability Act of 1949) which is a "blueprint for control of industry" by the President.

Two—The Brannan plan (S. 1971), a "strait-jacket plan for farming."

Three—Compulsory sickness insurance (S. 1679).

Mr. Davis said that each of the proposals is being presented as a "single reform for the benefit of the American people," but he warned that they are part of a "master plan to concentrate vastly expanded powers of government in the hands of a tightly knit group of planners in Washington."

CHILD PSYCHIATRY IS LECTURE TOPIC

Madison, June 2.—A special lecture on child psychiatry will be presented by Dr. W. Whitman Newell, Baltimore, associate professor of psychiatry at the University of Maryland school of medicine, at 8 p.m., Tuesday, August 1, in the medical school auditorium of the University of Wisconsin.

All physicians and students are invited to attend. His topic will be "Principles and Practices Used in Child Psychiatric Clinics."

REP. GLENN DAVIS

Sen. Cain Urges Total Study of Social Security

Hope to Delay H. R. 6000 Until Inquiry Ends

Washington, D. C., June 2.—In the midst of important debate on H.R. 6000 (expanded social security legislation), Senator Harry Cain of Washington has introduced a resolution (S. Con. Res. 92) calling for the establishment of a bipartisan Congressional commission to study a possible revamping of the social security system and to investigate the management, administration and conduct of the present social security office.

At the same time, the Senate is set to debate a revamped H.R. 6000 in which provisions for permanent and total disability insurance (opposed by AMA) are completely eliminated. However, administration leaders indicate they will fight to restore the provisions.

The effect of Senator Cain's resolution, if it passes in time, will be to delay passage of H.R. 6000 until the inquiry is completed.

Senator Cain has asked that Congress review its social security program to find out "where it is going" and to study the idea of a pay-as-you-go system.

He has emphatically urged a thoroughgoing investigation into the present social security administration—its management, administration, conduct and the role of the department in influencing social security legislation.

SENATE APPROVES HEALTH PLAN SURVEY

Washington, D. C., June 1.—The Senate has approved $37,800 for an extensive survey of health insurance plans to be made under the direction of the Senate Labor and Public Welfare Committee during adjournment.

Senator James E. Murray (D. Mont.), chief proponent of national compulsory health insurance and chairman of the Committee's health subcommittee, will supervise the survey.

The Committee is looking for a director to handle the project who will be acceptable to both Republicans and Democrats. Working under him will be two assistant directors, a Democrat and a Republican.

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Blue Shield Agency . . .

(Continued from page 499)

(Wisconsin Physicians Service) and the plan approved by the society but sold through private insurance carriers (Wisconsin Plan).

Dr. Dessloch pointed out that a basic service group contract covering only surgery and maternity is needed by many groups who want coverage somewhat less expensive than that provided by the standard group contract which includes anesthesia, x-ray and medical benefits.

The rate for the new contract, although not yet fully determined, will probably be about 25 per cent less than the present standard group rate on individual contracts ($.90) and about 10 per cent less on family contracts ($2.50).

The directing board of the Blue Shield Agency plans to offer additional benefits such as anesthesia, x-ray and medical by means of riders, at additional cost, as groups become educated to the need of fuller coverage.

Operations Summary Wisconsin Physicians Service

(Blue Shield Agency)

The following is a summary of operations and statistics of the Blue Shield Agency of the State Medical Society from Dec. 1, 1946 to Mar. 31, 1950:

Number of contracts	69,127
Persons covered	165,088
Earned premium Income	$2,435,439.35
Physicians' claims	1,769,977.90
Administrative expenditures	392,195.04
Available reserves	273,266.41
Doctors participating	2,113

The cost-plus contract was proposed as a means of covering certain large groups of employees who enjoy such stable employment and select risks that they are willing to become self-insurers of their own health care cases.

In such an arrangement, the employer will guarantee to reimburse the Blue Shield Agency for all actual benefits paid his employees, plus a predetermined fee for Blue Shield administration and reserve for contingencies.

The Blue Shield directing board pointed out, however, that this type of plan can only be used in a limited number of groups, since on a large scale it might defeat the well-established insurance principle that better risk groups help to carry the poor risks.

The Council clearly specified that cost-plus contracts would be written only under the closest supervision of the directing board.

June 30 is Deadline to Apply for Hospital Construction Funds

Madison, May 15.—All persons, organizations or communities interested in applying for federal funds to help build their local hospital must send their applications to the State Board of Health before June 30, 1950, to be eligible for consideration under the fourth annual federal appropriation to Wisconsin.

This advice was given recently by Vincent F. Otis, director of the hospital survey and construction division of the state board of health.

Revised Priorities Listed

At the same time he released a revised priority schedule of communities eligible for general hospital facilities. The new schedule shows that Lancaster, Boscobel, Chilton, Neillsville and Park Falls have "A" priorities.

Twenty other cities have "B" priorities and 16 others have "C" ratings. In determining the preference rating, special emphasis was given the need for construction of hospital and health facilities in rural areas and areas with low economic resources.

Plan Developed by 14 Men

The Wisconsin Hospital Construction Plan has been developed by a 14-man advisory hospital council from continuing surveys started in 1946. Its objective is to develop an interrelated system of general hospitals and related institutions which will be available to all the citizens of the state for a broadened program of medical service in all categories of illness.

State Health Council Elects New Officers

Madison, May 23.—The Wisconsin Public Health Council re-elected Mr. R. W. Bardwell, Madison, director of vocational schools, as president at its annual meeting on May 19.

Other officers elected were T. A. Duckworth, Wausau, first vice president; and Mrs. Otto Falk, Milwaukee, second vice president.

Dr. John C. Metternich, Rhinelander; Miss Susan Normann, Waukesha, and Dr. W. D. Stovall, Madison, were named directors.

Those continuing in office are Miss Gertrude Clouse, Madison, secretary; Harold Link, Kaukauna, treasurer; and C. H. Crownhart, Madison, Palmer Daugs, Lake Mills, and Mrs. Donald Shepard, Neenah, directors. Dr. E. H. Jorris, Madison, is council advisor.

The council was organized in 1948 and now has more than 230 members in the state. Its objective is to help organize communities to meet their own health problems.

Illinois Licensed 450 Foreign-Trained M.D.s in Last 10 Years

Chicago, May 27.—More than 450 foreign-trained physicians have been licensed to practice medicine in Illinois in the past ten years, according to an editorial in the May, 1950, Illinois Medical Journal.

Under the title "Illinois Has a Good Board," the editorial tells how the Medical Examining Board of the Department of Registration and Education in Illinois has acted to "sort the wheat from the chaff, and give those men who are good physicians, an opportunity to become good Americans, earning their living through the practice of medicine."

The following licenses were issued to graduates of foreign schools (other than Canadian) during the past ten years:

1939 - 81	1943 - 27	1947 - 26
1940 - 119	1944 - 13	1948 - 25
1941 - 78	1945 - 11	1949 - 24
1942 - 33	1946 - 17	Total - 454

Pointing out that "we must not lower our standards because of sympathy" for refugees from oppression, the editorial noted that "Illinois does not want a good physician who is not a good citizen; neither do we want a good citizen who is a poor physician to be allowed to practice."

Mine Workers' Journal Cautions Labor on Its Stand on Socialized Medicine

Chicago, May 18.—Labor is being cautioned to think carefully about its support of Truman's compulsory health scheme if it hopes to repeal the Taft–Hartley law, an editorial in the May 15, 1950 issue of the United Mine Workers' Journal indicates.

The following excerpts from the Journal reveal labor's growing belief that Florida's Senator Pepper lost the recent election because of his support for the Truman program:

"On the medical question, labor had better begin to think, because if resentment of the voters to National medicine in one-third of the States proves as beneficial to reactionary candidates as in the case of Smathers, the problem of repealing the Taft–Hartley Law—so long as both are linked in the Truman program—will be three times as difficult.

"Regardless of how lightly President Truman may seek to brush off the Pepper defeat, the fact remains that the over-all resentment against Pepper crystallized as a result of Pepper's all-out support of the Truman program.

"Pepper was up against an unreasoning wall of voters on this question and the more he said in support of National medical aid the more votes he lost."

Family Doctors Still Outnumber Specialists

Chicago, May 24.—General practitioners still outnumber the medical specialists in this country nearly two to one.

This is shown in the American Medical Association's new medical directory.

It lists 72,550 in general practice; 22,976 in general practice but giving some attention to a specialty; 54,891 full-time specialists; 12,536 in federal government service; 9,700 retired or in fields not related to medicine; 3,737 in administrative, editorial or executive positions related to medicine, and 24,887 interns, resident physicians or full-time physicians in hospitals.

The previous directory, issued in 1942, listed the United States as having 180,496 physicians. In the 1950 edition, the number is 201,277. This is a gain of 20,781 physicians in the past eight years.

States Being Forced to Use Federal Grants

Yet Only One State Got More Back in Grants Than it Paid in Taxes

Washington, D. C., May 29.—State finances are tightening up all over the nation and causing greater dependence on federal grants, according to the Washington office of the American Medical Association.

A review of the 1949 Census Bureau report shows that states' income dropped below expenditures by 7.2 per cent in 1949—a reversal of previous budget trends.

In 1948 income exceeded outgo in 32 states, but in 1949 outgo exceeded income in 33 states. This reversal took place despite the fact that federal grants to states increased 20 per cent in 1949.

Nearly $1,400,000,000 in U. S. Grants went to states in 1948—and more than $1,705,000,000 in 1949. This does not include nearly $3,640,000,000 in direct U. S. payments to individuals in states in 1949.

Only one state, Mississippi, received more money back from the federal government in grants than it paid in federal taxes. It received 107 per cent of its tax payments.

Other high return ratio states were Alabama, New Mexico, Wyoming and North Dakota, all with about 50 per cent return.

A high percentage of federal grants are in the health services field. hospitals, disease control programs, research, aid to the handicapped and old age assistance.

MEDICAL PLANS GET NEW TITLE

Chicago, May 23.—"Blue Shield Medical Care Plans" is the new name of the national association of medical-society-sponsored surgical and medical care prepayment programs.

Following a recent Montreal conference of the executives of these programs, the corporate name of Associated Medical Care Plans was dropped in favor of the new title.

The action will stimulate public understanding and acceptance of physicians' care plans which have long been associated in the public mind with Blue Cross, the hospital care plans.

Examiners Okay 38 Foreign Schools

River Falls, June 3.—The Wisconsin State Board of Medical Examiners has agreed to accept applications for licensure from graduates of 38 foreign medical schools approved by the American Medical Association.

The announcement was made at a recent meeting of the Board in Madison.

The 38 schools had been found to be reliable and reputable by the Council on Medical Education and Hospitals of the AMA after a study instigated by Dr. H. H. Christofferson, Colby, member of the Wisconsin Board. AMA approval was announced last February.

In a resolution passed at its meeting, the Board recalled that it had adopted a policy in 1937 of "not accepting for examination any graduate of a foreign university, with the exception of graduates from approved Canadian schools."

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Lancaster Doctors Urge County Hospital

Lancaster, Wis., May 20.—The doctors of Grant county are leading a movement for the construction of a general hospital and home for the aged at Lancaster, according to the *Lancaster Independent.*

Lancaster has top priority for federal aid under the Wisconsin hospital survey and construction program.

At a recent meeting of the Lancaster Association of Commerce, citizens were discussing the need for a new county home for the aged with hospital facilities for the indigent.

Dr. Leo H. Hudson, Lancaster, suggested that the idea be expanded to build a "modern and up-to-date county general hospital where doctors from the entire county could bring their patients for surgery, and hospital care and treatment," reported the Independent.

The newspaper editorialized that a certain number of beds "could be reserved for the indigent, but there would also be a revenue producing side to a county general hospital."

FBI ENDS JOB AT AMA OFFICE

Chicago, May 22.—Federal Bureau of Investigation agents have completed their job within AMA headquarters, reports Dr. George F. Lull, secretary and general manager of the association.

Four to six agents have spent the last seven months scanning the voluminous files and records at AMA headquarters. When the agents started their job last October, Attorney General Howard McGrath, former chairman of the Democratic National Committee, announced in Washington that the Justice Department wanted to know if any monopoly existed in connection with prepaid medical care plans.

During the course of their work, the agents had many letters and records reproduced, photostatically. The AMA has matching copies for its own files.

DR. BERNARD P. WALDKIRCH, De Pere, presents the State Medical Society's outstanding health achievement certificate to Helen Gosz of the Morrison 4-H club at a recent meeting of the Brown County 4-H Leaders' Association.

Veterans Agency Renews Contract With VA; Program Levels Off

Madison, June 4.—The Wisconsin Veterans Medical Service Agency of the State Medical Society has renewed its contract with the Veterans Administration to handle "home-town" medical care for veterans in the state.

Dr. J. S. Supernaw, Madison, chairman of the agency's operating committee, made this announcement at the June meeting of the Council after more than a month of negotiating with the VA.

Dr. Supernaw reported that the volume of "home-town" medical care being rendered through this program has leveled off at about $20,000 in VA authorization per month.

Since the start of the program in 1947, the Agency has received VA authorization to permit doctors to render nearly $1,300,000 in medical and hospital care to Wisconsin veterans.

Physicians have filed claims with the VA for only slightly more than $1,000,000 of the amount actually authorized for their use. Dr. Supernaw explained that the unused portion came about because Wisconsin physicians found that the amount appropriated by the VA was more than was necessary to provide adequate, high quality care for Wisconsin veterans.

The VA has actually reimbursed Wisconsin doctors, through the Agency, the sum of $902,123 in the past three years.

Dr. Aageson Named to Insurance Committee

Madison, June 4.—Dr. H. A. Aageson, Oconto, has been appointed to the Wisconsin Plan Committee to fill the unexpired term of Dr. H. E. Kasten, Beloit, who submitted his resignation at the recent meeting of the Council.

Dr. Aageson is in full time general practice and is on the staff of the Oconto county and city hospital. He is a graduate of Rush Medical College, and took a residency in surgery at Milwaukee County hospital.

Dr. Kasten asked to be relieved of his committee work with the Wisconsin Plan because of his duties as chairman of the Coordinating Committee on Prepaid Plans of the State Medical Society.

Wisconsin M. D.s Prove That A Doctor's Training Never Ends

Nearly 1300 Doctors Attend Yearly Clinics

Madison, June 3.—Nearly half of the members of the State Medical Society have attended one or more of the postgraduate clinics conducted by the Society's Council on Scientific Work during the past year, it was revealed by Dr. J. M. Freeman, Wausau, chairman of the Council.

In the period between July 1949 and July 1950 the Society has held 14 day-long scientific education meetings for physicians. These include cancer and industrial health clinics, and the regular postgraduate teaching clinics.

A total of 1,267 physicians attended these clinics—more than 43 per cent of the membership of the Society.

This does not include the 1,510 physicians who attended the annual meeting of the Society held last October in Milwaukee, nor does it include the monthly meetings of county medical societies at which scientific papers are discussed.

The industrial health clinics held in April and May this year had the following attendance: Kohler Mfg. Co., Kohler, 69; Consolidated Water Power & Paper Co., Wisconsin Rapids, 40; Globe Union Co., Milwaukee, 80.

During the same months, the annual spring or postgraduate teaching clinics had the following attendance: Baraboo 72, Janesville 97, Racine 129, Chippewa Falls 49, Wausau 83 and Green Bay 112.

"Come Out Fighting," Editor Urges Doctors

Lowell, Mass., May 27.—A "thoughtfully-planned" nationwide advertising campaign to tell the people "the doctor's story and the black clouds that today hang over his head," was urged by Thomas F Costello, editor of the *Lowell Sun* at the annual meeting of the Massachusetts Medical Society.

"Put an end to the shadow-boxing and come out fighting. You know the American people well enough to know that they love a fighter. You owe it to them to put up your best fight."

Senate Drops Idea of Total Disability Coverage in H. R. 6000

Washington, May 15.—The permanent and total disability program advocated by House-approved bill H.R. 6000 (social security revision) has been dropped by the Senate Finance committee, it was announced by committee chairman Senator George. This program has been vigorously opposed by the medical profession.

Physicians Excluded

Agreement was reached on several other provisions of the bill. The House wanted to extend Old Age and Survivor's Insurance coverage to 11 million more persons; the Senate agreement is to cut this to 8½ million. The Senate committee, however, proposes to grant higher benefits to those now receiving OASI benefits.

Physicians and other professional people are not covered in the bill although coverage was extended to about 800,000 regularly employed farm workers.

The Senate committee also agreed to make coverage optional for employees of institutions and organizations (including hospitals) owned and operated by religious denominations. Coverage is compulsory for all other non-profit institutions and organizations.

Truman Tries Again for Welfare Department

New Plan Merely Renames Federal Security Agency

Washington, D. C., June 2.—President Truman has renewed his attempts to create a new cabinet department of health, education and security.

Last year a similar proposal (Re-organization Plan No. 1) was defeated by the Senate. The new proposal (Re-organization Plan No. 27) was sent to Congress on June 1 and proposes that the cabinet post include chiefly the functions now under the federal security administration, headed by Oscar R. Ewing.

President Truman said he has modified the proposal to meet objections raised in Congress last year. He said the new plan would retain the present statutory powers of the surgeon general and the commissioner of education.

However, these officials, together with the social security commissioner, would report directly to the new cabinet secretary, instead of to the President.

Medical men point out that Reorganization Plan No. 27 merely changes the name of the federal security agency and enlarges its scope without effecting much needed coordination of federal medical activities.

The American Medical Association has long urged that a federal department of health be established with a physician secretary of cabinet status.

AT THE MADISON LABOR EXHIBITION more than 50,000 persons had an opportunity to view the Exhibit of the State Medical Society shown bove. Visitors picked up more than 11,000 pamphlets on health subjects and socialized medicine.

This and similar exhibits have been shown at the Wisconsin Congress of Parent and Teachers, Wisconsin Farm and Home Week and the "Amvets" state convention.

LAYMEN TO ACT ON ROCK COUNTY SOCIETY COMMITTEES

Society Says Socio-Economic Matters "No Longer Exclusive Right of Doctors"

Janesville, June 7.—Laymen will soon be appointed to serve as advisors on several committees of the Rock County Medical Society because the Society believes that medical economic problems are "no longer the exclusive right of doctors."

Dr. V. W. Koch, Janesville, president of the society, made the announcement after this recommendation of the committee on public relations had been approved at a recent (May 23, 1950) meeting of the medical society.

He said that the Rock County Medical Society feels that "the administration of the practice of medicine with its sociological and economic aspects is no longer an exclusive right of doctors of medicine.

"The public who pays the bill has a right to know something about how the doctors arrive at the various formulas for handling of their administrative and economic problems.

"By the same token, physicians have a right to know something about the processes that go on in lay organizations having for their primary objectives the health of their members," Dr. Koch reported.

It is planned that representatives of management and the AFL and CIO unions will be appointed to committees on public health, school health, legislation and public relations within a few months.

Members of the committee which requested lay participation in medical society affairs include Drs. Koch, W. A. Munn, and W. T. Clark, Janesville, and W. J. Mauermann, J. C. Springberg, and H. E. Kasten, Beloit.

DR. V. W. KOCH

MILWAUKEEAN GETS C-P SCHOLARSHIP

Chicago, May 15.—A Milwaukee physical therapist has been awarded a scholarship for specialized training in cerebral palsy, it was announced by the National Society for Crippled Children and Adults. She is Anita Koehnke of the Milwaukee Association for the Crippled.

Voluntary Plans Try "Catastrophic" Coverage

Madison, June 5.—Medical societies and private insurance carriers are currently engaging in a great deal of study and experimentation to find a practical method of providing voluntary insurance protection against the medical expenses of catastrophic illness.

California is First

First of the plans in operation is the special "catastrophic" coverage policy of California Physician's Service, the medical society plan of California.

Covers 24 Diseases

This policy, attached to the standard medical-surgical policy as a rider for a small additional premium, provides benefits of $5,000 or for two years, whichever comes first, for all expenses incidental to the care of 24 chronic or long-term diseases.

Insurance Company Plan

At the same time, insurance companies are studying the possibility and gathering actuarial data. One insurance company is providing similar coverage to the employees of a large industrial concern. Although the plan is operating under unusually favorable conditions, the results are expected to be of major significance.

Health Insurance Issue Won't Stay Dead Long

Washington, D. C., May 27.—Although national compulsory health insurance is a dead issue for this session of Congress, all indications in Washington are that it will not stay dead for long, according to the AMA Washington office.

It pointed out that, in the coming campaigns, both the AFL and CIO are expected to make good use of a new pamphlet produced by the Democratic National Committee to promote the Truman Health Plan.

Bite Into This Pill First

"Better Medical Care Than *You* Can Afford" is the title of an attractive, cleverly illustrated little booklet put out by the Democratic national committee.

As could be guessed, its purpose is to sell the idea of the Truman administration proposals for greatly expanded government health programs, new and bigger federal subsidies for all sorts of things in the health field, *and* compulsory health insurance.

It offers alluring pictures. Doctors everywhere for everyone. Hospitals, too. More medical research, more health officers, more nurses, sanitary services, etc.

Most of this would be "free." The rest of it would be yours for just a little sum held out of your pay check. The best of doctors, medicines and hospital care would then always be yours whenever you needed them, as long as you needed them. You'd never have to worry about the bills.

The pink candy coating of promises is spread on thick. Underneath it all, however, would be the bitter dose of compulsion, undetermined costs, bureaucracy and more tax burdens.

There still isn't a single good reason to swallow the thing until we know a lot more about what the dose would do to us.

—The Milwaukee Journal
May 19, 1950

Paroxysmal Ventricular Tachycardia*

Report of a Case

By HOWARD L. CORRELL, M. D.
Milwaukee

H. L. CORRELL

Doctor Correll, an assistant clinical professor of medicine at Marquette University School of Medicine, graduated from the University of Wisconsin Medical School in 1935. A diplomate of the American Board of Internal Medicine, the doctor maintains a private practice in that field in Milwaukee.

THE patient in this case is a 60 year old white male who suffered an extensive myocardial infarction of the posterior wall in March 1941. Paroxysmal ventricular tachycardia first developed in April 1946, requiring oral quinidine sulfate in high doses for conversion to sinus rhythm. He has been maintained on quinidine up to 21 grains daily, and any reduction or discontinuance has been followed by recurrence of the tachycardia on at least four occasions, two requiring quinidine lactate, 7½ grains intravenously to convert. On other occasions quinidine sulfate in oral ascending doses at one to two hour intervals eventually converted the rhythm with total doses of 45 to 54 grains in a four to five hour period. In the past year he has suffered from recurrent episodes of congestive failure, and he is currently convalescing from an episode of congestive failure and tachycardia. With his attacks of tachycardia he suffers from weakness, vertigo, syncope, and substernal oppression and, recently, heart failure. He represents an interesting and important clinical problem which must be recognized to be properly treated.

Paroxysmal ventricular tachycardia is the most serious of the five types of paroxysmal rapid heart action compatible with life if persisting more than five minutes. In certain forms at least, it is a precursor of ventricular fibrillation, which is fatal if of more than several minutes' duration. The other forms of rapid heart action which may be paroxysmal are auricular fibrillation, auricular flutter, auricular tachycardia, and nodal tachycardia.

Ventricular tachycardia is the least common type and in 90 per cent of cases is associated with serious heart disease, most commonly with acute or subacute myocardial infarction. Digitalis intoxication is the next most common exciting cause. Occasionally it occurs in otherwise normal hearts. Quinidine poisoning, epinephrine, and certain anesthetic agents have been implicated infrequently.

Symptoms are variable and dependent on the efficiency of blood flow, the state of the heart, and the vasomotor tone. In general, the greater the heart damage, the greater the symptoms; and the longer the duration of the attack, the greater the symptoms such as palpitation, pain, vertigo, syncope, peripheral collapse, or heart failure. Sudden death from the development of ventricular fibrillation may occur.

Recognition is dependent upon electrocardiographic studies, although it should be suspected clinically in five instances: (1) a sudden tachycardia in a heavily digitalized patient; (2) a sudden tachycardia occurring during auricular fibrillation; (3) a sudden tachycardia in a patient with myocardial infarction; (4) a sudden tachycardia failing to respond to vagal stimulation; and (5) a sudden tachycardia with alterations in intensity of the heart sounds or slight irregularity of the rhythm. The rate may be from 100 to 270.

Electrocardiographic criteria for the diagnosis of ventricular tachycardia are the presence of one of the following: (1) demonstrable "P" deflections at a slower rate than the ventricular complex; (2) paroxysms of more than three rapid abnormal ventricular deflections in auricular fibrillation; (3) onset of tachycardia with an abnormal ventricular complex; or (4) close resemblance of the complexes of the tachycardia to ventricular premature beats recorded during normal rhythm in the same lead.

Rhythms confused with ventricular tachycardia are: (1) supraventricular tachycardia in patients with bundle branch block; (2) supraventricular tachycardia with aberrant ventricular conduction; (3) supraventricular tachycardia in Wolff-Parkinson–White syndrome retaining the aberrant ventricular conduction; or (4) auricular flutter with 1:1 block and aberrant ventricular conduction.

Treatment of ventricular tachycardia depends to some extent on recognition of the precipitating factors. If due to toxic effect from digitalis or other drug, that drug must be discontinued.

Digitalis is not used in treatment and is dangerous, probably because of the danger of precipitating ventricular fibrillation. It is important to emphasize that an arrhythmia occurring during the course of myocardial infarction be electrocardiographically disproved as ventricular tachycardia before digitalis is used.

The drug of choice is quinidine in a dosage schedule taking into account its rapid excretion. It is pushed to toxicity or reversion of the rhythm to normal and is then maintained at a reduced dose

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

at four to six hour intervals for a long period of time, and permanently, if necessary. Various quinidine schedules are used, the two most frequently used by us being one or two hour schedules after a trial dose starting with 1½ to 3 grain doses and doubling every one to two hours until reversion or toxicity occurs.

In the unusual cases, in otherwise normal hearts in which disturbances in sympathetic tone are responsible, sympatholytic drugs, such as ergotamine, have been reported useful.

In summary, patients with severe coronary artery disease or those taking digitalis in whom there develops a tachycardia, which may be regular or slightly irregular, should be suspected of having ventricular tachycardia, and digitalis should be withheld until the diagnosis is established or ruled out by electrocardiography.

REGIONAL MEETING OF AMERICAN COLLEGE OF PHYSICIANS TO BE HELD IN MADISON

On November 18, the American College of Physicians North Central Regional Meeting will be held in Madison. Registration will begin at 8:00 a.m., and the meeting will consist of a series of scientific papers presented throughout the day. A scientific exhibit of wide general interest is planned in connection with the meeting.

This gathering will be held in the Wisconsin Union Theater on the campus of the University of Wisconsin. A luncheon will be served in the Wisconsin Union at noon for all registrants wishing to participate.

It is to be especially noted that this postgraduate instructional session is open to all interested physicians whether or not they are members of the American College of Physicians. Members of the College are urged to bring along their colleagues as guests.

At a later date the entire program will be printed in this publication for the information of all physicians.

INTERNATIONAL COLLEGE OF SURGEONS ANNOUNCES CONVENTION DATES

The fifteenth Assembly of the United States chapter of the International College of Surgeons will be held in Cleveland, October 31–November 3, at the Cleveland Public Auditorium. The headquarters hotel will be the Cleveland Hotel.

Convention details will be announced later.

Cholera in Wisconsin, 1832-1834

By PAUL F. CRANEFIELD*
Madison

THE terrifying pandemics of cholera in 1832, 1848, 1866, and 1873, sweeping from India to the Middle East, overland to Russia, down into Germany, France, England and Ireland, each time took the New World as their final victim.[1]

The first epidemic to burst from the bounds of the East started in India in 1826, reached Moscow via Persia in 1830, and England by ship from Riga in 1831. The emigration from England and Ireland inevitably carried the disease to Quebec, possibly as early as April 1832, and to New York, June 24, 1832.[2] Its journey west was mercilessly swift, aided as it was by the travels of an infected army.

Wisconsin might have been spared the cholera until the next pandemic had not Black Hawk led the Sacs into rebellion or had not General Winfield Scott, attempting to reach the scene of the uprising, continued west after he knew his army was infested with the disease. Both did, and the first cholera epidemic to reach the United States penetrated its western margin of settlement sooner than it reached the more populous Ohio Valley.[3]

The Wisconsin part of the Michigan territory was enough alarmed by the Sac war to raise an army and go beat them, without waiting for Scott. Father Mazzuchelli, Catholic missionary and founder of the convent and college at Sinsinawa, says in his memoirs:

> The warlike tribes of the Sacs and the Foxes with their stubborn war against the United States government had in 1832 spread terror and confusion for many months throughout the southern and western parts of Wisconsin Territory. There some of the citizens had been barbarously murdered but their death was avenged by the united forces of the settlers who, pursuing the hostile and rebellious tribes, after difficult and bloody encounters, drove the wretched savages to the necessity of swimming across the vast river Mississippi near Prairie du Chien.[4]

Remote settlements, surrounded by hostile Indians, communicating with each other by long arduous voyages on dangerous waters, a pair of fur-trading posts, each with its fort, and with another fort halfway sentinel on the trail between, Green Bay and Prairie du Chien in 1832 could hardly have been surprised to suffer from Indian uprisings and were doubtless not surprised when the federal troops arrived too late to fight the Indians but soon enough to infect the country with the Asiatic cholera.

Who, if anyone, is to blame for the spread of the disease is not clear. The army was infected by traveling from Buffalo, New York, in a boat which had only recently carried diseased Irish immigrants.[5] General Scott finally ordered the diseased troops quarantined at Fort Dearborn (Chicago), Illinois, until the epidemic subsided, but a few soldiers entered Chicago and went on, after a time, to Rock Island, Illinois, where an epidemic broke out on Aug. 26, 1832.[6]

McClellan, in Wendt's "Asiatic Cholera," places no blame at all on Scott, but says:

> By a gross disobedience of orders fresh victims were infected. By them the disease was carried over one hundred and fifty miles of almost wilderness to the Mississippi River, when the troops of General Atkinson, returning from a victorious campaign [against Black Hawk], were infected and an epidemic started which cost thousands of lives.[6]

Scott, in a report to the secretary of war, dated Rock Island, Illinois, Sept. 1, 1832, says of his quarantine orders:

> The letters were all left unsealed, and indorsed with my rank and name to excite curiosity, and to induce postmasters and others to read them and give publicity to my admonitions. In short, I had erected a paper barrier around Chicago which no company of Rangers, though ordered to report to me there, could ignorantly pass.[6]

General Robert Anderson (defender of Fort Sumter at the beginning of the Civil War) tells how the disease went up the river to Prairie du Chien:

> General Scott having received information from Colonel [Zachary] Taylor of the capture of Black Hawk and a few of his chiefs he detailed me . . . to go to Fort Crawford . . . We left Rock Island early in the day and before night there were indications of the cholera among the soldiers on board the boat . . . [The soldiers then ill were left at Galena] . . . We then continued our trip to Fort Crawford, where I delivered my orders to Col. Taylor. By that time I had the cholera myself, and was scarcely fit for duty.[7]

Scanlan, in his book "Prairie du Chien,"[8] states that General Anderson never reached Prairie du Chien, but Anderson's statement does not bear that out.

It has frequently been reported that infected troops entered the Northwest, and possibly Wisconsin, but no particular study has been made of the spread among civilians or of the later outbreaks. The first pandemic described as including Wisconsin is that of 1848, studied by Middleton.[9]

John H. Fonda, a resident of Prairie du Chien in 1832, indicates at least a limited spread to civilians:

> The cholera raged terribly among the troops the year of 1832. One hundred soldiers died at Ft. Crawford in two weeks . . . Only four citizens died of the cholera, and those in one house.[10]

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* Graduate student and research assistant in physiology at the University of Wisconsin Medical School. This paper was written under the supervision of Dr. E. H. Ackerknecht, professor of history of medicine at the University of Wisconsin Medical School.

Scanlan denies that there was an epidemic, and says that Beaumont (see below) was not at Prairie du Chien at that time. He states that there is no record in the muster rolls of Fort Crawford indicating such sickness or any death resulting therefrom among the soldiers of the garrison.

We have further, somewhat conflicting, evidence from Deborah Beaumont Martin:

The disease was brought west by the troops under General Scott who was detailed to distant Wisconsin in order to quell the Winnebago [there were Winnebago uprisings, too] uprising. All through the summer of 1832 the cholera raged through the villages and garrisons along the Mississippi and Green Bay. Dr. Beaumont was then stationed at Fort Crawford and did wonderful service in caring for the terrified inhabitants and in sending to Fort Howard and other badly stricken districts formulas and methods of treatment. "The greater proportional number of deaths in the cholera epidemics," he records, "are in my opinion caused more by fright and presentiment of death than from the fatal tendency and violence of the disease." But whatever the cause the fatality was great, especially in Green Bay.[11]

A direct statement about Green Bay comes from Elizabeth Therese Baird:*

As I think of those days it makes me almost tremble even now. The cholera first visited us in 1832. Mr. Baird had to go to Shantytown every day, to his business; I never saw him mount his horse without saying to myself "Shall I ever see him again?—the cholera threatening on one hand, the Indians [Winnebago?] on the other."[12]

In considering the epidemiology of early Prairie du Chien and Green Bay, it must be remembered that the two cities were much travelled between, in spite of the difficulty involved. The presence of a fort on the way between testifies to the importance of the route. This route was regarded as of some value by ambitious citizens of Green Bay who in 1832 memorialized Congress to improve it as an important link between the upper Mississippi and the Great Lakes.[13]

An epidemic might reach Green Bay from New York City via Buffalo, New York, and the Great Lakes, from Quebec via the St. Lawrence and the Great Lakes, or from Prairie du Chien. Prairie du Chien might, in turn, be infected from Green Bay or any place on the Mississippi. Since New York, Quebec, and areas along the Mississippi were infected in 1834, no one source can be proved for that latter epidemic.[14]

It was the belief of McClellan that the river traffic was a very important agency of spread, responsible for an epidemic in 1833:

Cholera visited the United States in 1833, 1834, and 1835, but no evidence can be found that the troops had any agency in its spread during either steamboats on the Mississippi, Ohio, and Missouri rivers were cholera infested, and that their agency in the diffusion of cholera in those years was as great as it has been in succeeding epidemics.

I find from the reports of Surgeon R. C. Wood, U. S. Army, that at Fort Crawford, on Prairie du Chien cholera occurred in August, 1833; that there were twenty-three decided cases with six deaths, while very few escaped the choleriac diarrhoea, and at the same time in the town of Prairie du Chien 12 or 15 deaths occurred.[15]

Before consideration of the epidemic of 1834, the distribution and size of the population in 1832 and 1834 are of interest. There were many more people in Wisconsin in 1834 than in 1832, for the final crushing of the Indians made the area more popular. In particular, the defeat of the Indians made farming safer, whereas in 1832 the only safe places were in or near thickly populated, defended areas, such as the mining area in the southwest and the trading posts of Prairie du Chien and Green Bay. Neglecting the heavy immigration into Milwaukee county in 1835 and 1836, the federal census of 1830 is a fair approximation to the population in 1832 and the territorial census of 1836 is a not quite as good approximation to that of 1834.[16, 17]

	1830	*1836*
Iowa	1587	5324
Crawford	911	850
Brown	1263	2706
Milwaukee (part of Brown)		2893

(The figures given for 1830 for Crawford include 229 persons at Fort Crawford; those given for Brown for 1830 include 221 at Fort Howard and 160 at Fort Winnebago.)

It seems likely that, though there were many more people in Wisconsin in 1834, the urban areas of Green Bay and Prairie du Chien had not increased much, but that the immigration had flowed into the farm land of eastern Wisconsin. At all times Green Bay and Prairie du Chien were, as mentioned above, in constant, though not easy, communication, via the Fox and Wisconsin rivers.

The epidemic of 1834 is authenticated for Green Bay, again by Mrs. Baird:

In November 1833 Father Mazzuchelli came with two nuns to Green Bay. Sister Clare, an American lady, was superioress, the other was Sister Therese . . . These sisters were here during that fearful cholera visitation in 1834, when Father F. [T.] J. Van den Broek was stationed at Green Bay.

The conflict in memoirs made it advisable to consult contemporary letters in the possession of the Wisconsin State Historical Society. It is surprising that little reference to the epidemic was found. Among the sources consulted were the Fonda papers, the Doty letters and the Doty microfilm, the Cadle papers, the letters to the American Home Missionary Society from local missionaries, the letters and journals of the Rev. Cutting Marsh, the Baird papers, the Kemper papers, the Lawe letters, the Lawe–Grignon correspondence, the Dodge papers, the Dousman papers, and the Wisconsin Manuscript Collection for 1832–1834.

* Medical readers will know of Mrs. Baird's descendants, prominent in the profession: Dr. Henry Baird Favill, Chicago internist (Henry Baird Favill Memorial Volume, Chicago, 1917); his son, Dr. John Favill, Chicago neurologist (Arch. Neurol. & Psychiat. 58:72–76, [July] 1947); and Dr. H. Kent Tenney, Jr., Madison pediatrician and member of the staff of the University of Wisconsin Medical School. [any?] of those years. It is a notorious fact that

A letter from D. E. Brown to the Rt. Rev. Jackson Kemper* on Oct. 6, 1834, says:

Mr. Van Petts has just received a letter from Mrs. Sarah B. Cadle [wife of the Episcopalian missionary at Green Bay] in which she says that the colera [sic] has made its appearance at the Mission and about twenty children have been attacked slightly with it that [it] has been very fatal in some families in the vicinity . . .

This second and third hand account is rather overshadowed by Father T. J. Van den Broek's memories of the time. Father Van den Broek, a missionary to the Indians,[18] wrote for home consumption in Holland, and I am indebted to Dr. H. J. van Baaren of the University of Wisconsin Medical School for this translation:

The cholera was prevalent, raging so strongly that in many houses three or four persons were attacked by it. It sometimes happened that the patients died at my side, even during confession as I was giving them the last rites. Not finding enough hands to dig the graves we were forced to bury four or five people in one grave. It was often impossible to find anybody to bury the bodies so that I, myself, assisted by two sisters of the order of St. Clara, who were there to teach, did so. The cords which the sisters wore as belts had to be used to lower the bodies into the graves, and while we were busy with the burial, sometimes hurried people came from other parts to call me to the dying.[19]

The only, very indirect, reference we have to the disease in Prairie du Chien in 1834 is also the only information available on prevention. It is from Father Mazzuchelli's Memoirs:

In September 1834 the superstitious nation [Winnebago] had heard the news that there had been some deaths from this plague at Prairie du Chien, a hundred miles to the westward. That same day when the sun was about setting in a clear sky, the braves set to work loading their guns and shooting them off towards the west in order to *kill the cholera*, as they said.[20]

Father Mazzuchelli, unfortunately, gives no hint of the nature of the methods employed by the local white population. In some parts of the country the whites used the doubtless more efficient and less superstitious method of shooting cannon to kill the cholera.[21]

Although these epidemics broke with great ferocity upon an already terrified population, they did not deter immigration, for, once the Indians were quieted, people started coming in so fast that Wisconsin was made a territory in 1836.

Neither this epidemic nor that of 1849–1850 seems to have set back the progress of the state. Cholera came to most as a calamity of nature, not, like the Sacs, as something to be avoided or defeated.

This pioneer habit of regarding disease as just another burden placed by nature upon frontier life, plus a certain zealous determination to conquer the frontier, has been noted by Ackerknecht in his study "Malaria in the Upper Mississippi Valley." In this paper, Ackerknecht, e.g., quotes a pioneer as saying of another pioneer with malaria, "He ain't sick, he's only got the ager."[22]

This habit plus the already established habit of civic boosting (to raise land values?), may account for the paucity of contemporary reference to the epidemics. The *Green Bay Intelligencer*, Wisconsin's first newspaper, makes no reference to the epidemic of 1834, although it published no papers between Aug. 21 and Oct. 9, 1834, possibly because of the epidemic. The issue of October 9 is taken over by news of the new land grant act.

The attitude of the *Intelligencer* to disease (and climate) may be seen in a letter from a prominent Green Bay citizen to an inquirer, describing Wisconsin. The paper reprinted this letter, with approval, on Feb. 5, 1834.

The temperature has a greater evenness here than at any place I was ever in, which is not only beneficial to health but . . . renders the winter season fitted for business and pleasure . . . The weather in October was as warm as June and in the middle of the month the ground was covered with flowers. The warm weather continued until Christmas . . . This salubrity of climate renders the health of the place perfect, so much so that the oldest inhabitants maintain that no case of ague or fever ever originated here, and it is evident that there are no prevailing diseases that can be called epidemics or peculiar to the country.

Modern Wisconsin citizens, long free to worry more about their sinus trouble than about cholera, may judge from this letter the pretences under which their ancestors were lured to this state with its "winter a season fitted for business and pleasure."

* I am indebted to the Rt. Rev. B. F. P. Ivins, Bishop of Milwaukee, for permission to consult the Kemper papers.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Early Handling of Apoplexy with Aminophylline

On the assumption that apoplexy is the direct result not of primary vessel rupture but rather of primary vascular spasm, F. Mainzer[1] (Jewish Hospital of Alexandria, Egypt) has been treating apoplectic seizures with intravenous aminophylline since 1937. In a series of cases in which there was fully developed hemiplegic paralysis the impression was gained that this measure had a favorable influence on recovery of function, but it was recognized that it is difficult objectively to substantiate such an impression. The results in 5 cases in which it was possible to use the agent shortly after the beginning of the attack, were astounding.

These 5 patients, aged 52 to 84, suddenly lost consciousness and fell into deep coma, usually accompanied by stetorous breathing, loss of corneal reflexes and pupillary reactions, a positive Babinski sign on one or both sides, and in some instances urinary incontinence. In 3 cases a severe psychic shock preceded the seizure. In 1, blood pressure was under 140 mm. of mercury and in another over 250; in the others it was 150 to 180. In 4 cases, pressure during the attack was considerably higher than before or after.

In all cases consciousness returned in three to five minutes following intravenous administration of 240 mg. of aminophylline. Four of the patients could get up and walk in 15 minutes. In 1, the neurologic signs of brain involvement disappeared with the return of consciousness; in 3 instances these signs were still obtainable 24 to 48 hours later. In one 84 year old patient with hypertension, the apoplectic stroke caused such severe respiratory disturbance that hemorrhage into one of the ventricles was considered. But even in this case, return of consciousness followed immediately upon injection of aminophylline, and paralysis did not occur. However, the attack in this individual was followed by rapidly progressive loss of memory and initiative, sleeplessness, and complete loss of appetite, developments which proceeded to a fatal outcome in about six months.

In a sixth patient an apoplectic episode, not handled by aminophylline therapy, left the patient with a speech disturbance, paralysis of the right arm and some weakness of the right leg upon recovering conciousness several hours later. On the following day there was a positive Babinski sign and exaggeration of the right patellar reflex. In the second night the patient again went into coma with noisy respirations. Twenty minutes after the beginning of this coma, aminophylline was given intravenously and consciousness returned at once. Neurologic findings on the next day were precisely those of the day before, but the patient later recovered except for persistent slight rigidity of the right leg.—HARRY BECKMAN, M. D.

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NATIONAL GASTROENTEROLOGICAL ASSOCIATION OFFERS POSTGRADUATE COURSE

The National Gastroenterological Association announces that a course in postgraduate gastroenterology will be given at the Hotel Statler, New York, on October 12–14.

The course, which will again be under the personal direction of Dr. Owen H. Wangensteen, professor of surgery at the University of Minnesota Medical School, will cover the following subjects: diseases of the mouth, diseases of the esophagus, peptic ulcer, diseases of the stomach, diseases of the pancreas, cholecystic disease, psychosomatic aspects of gastrointestinal disease, diseases of the liver, diseases of the colon and rectum, and other miscellaneous subjects, including pathology and physiology, radiology, and gastroscopy.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, New York.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

A Simple Diagnostic Gelatin Liquefaction Test for Stool Trypsin in Fibrocystic Disease of the Pancreas

Fibrocystic disease of the pancreas is a congenital disorder in which the clinical signs of a celiac syndrome, resulting from pancreatic exocrine insufficiency, are associated with varying degrees of pulmonary disease, such as chronic bronchitis and bronchiolitis, bronchiectasis, and recurrent attacks of pneumonia.

Significant advances have been made in the medical management of this condition, but too often therapy has proved inadequate. Recently, our interest has been directed to a report by Ayers, Stowens, and Ochsner of New Orleans, regarding a new treatment, consisting of sympathetic denervation of the pancreas by splanchnic block with procaine hydrochloride, followed by complete splanchnicectomy on the right side. Studies are still in an early stage, but so far the procedure shows promise of relieving symptoms and limiting the secondary and fatal complications of this disease.

It has been said that conclusive laboratory diagnostic evidence of fibrocystic disease is afforded by the demonstration of absent or decreased enzymatic activity in aspirated duodenal contents, provided that other conditions such as pancreatic duct obstruction, congenital anomalies, hemochromatosis, and syphilis with pancreatic involvement can be ruled out. It is important to emphasize, however, that duodenal catheterization of a frightened seriously ill child may be difficult or even impossible; also, that all laboratories are not prepared to properly examine duodenal contents.

Much favor has been given recently to the use of a relatively simple screening test which quickly and roughly estimates the proteolytic activity of stools by determining their ability to liquefy gelatin. Schwachman, Patterson, and Laguna of the Children's Medical Center in Boston believe that three separate stool examinations by this test in infants are sufficient either to eliminate or to make probable the diagnosis of pancreatic insufficiency. They caution against conclusions and interpretations based upon a single examination and strongly recommend enzymatic examination of duodenal contents in all cases of doubt.

The following notes are considered important to individuals making use of the gelatin liquefaction test:

1. Two procedures may be used: (*a*) a test tube method and (*b*) a gelatin film method. The former is considered slightly more reliable, because x-ray film may change its properties when exposed to varying periods of storage and change in temperature. *However, the film method is easier to perform and lends itself readily to office use.* Difficulty with the film method is usually eliminated by running adequate controls when new film is used (normal infant stools or a standard trypsin solution). Photofilm is less reliable than x-ray film.

2. The test seems to have an accuracy of over 95 per cent in infants. Very occasional stool preparations of normal infants or infants ill with a condition not associated with pancreatic disease fail to liquefy gelatin. Careful consideration must be given to all negative tests, therefore, and must be supplemented with proper examination of duodenal contents in confusing cases.

3. The accuracy of the test is decreased in older children. The administration of a laxative to older individuals with absent tryptic activity frequently results in stools possessing definite activity.

4. The proteolytic ferments of intestinal secretion, certain intestinal bacteria and a variety of foods are insufficient to give a positive gelatin liquefaction test.

5. Stool specimens should be examined within 24 hours, because significant bacterial tryptic activity may develop in older specimens.

6. *Stool specimens must not be contaminated with urine, because urine contains a protease capable of liquefying gelatin.*

Procedures

A. Test Tube Method.—1. Prepare a one-fifth dilution and a one-tenth dilution of feces by adding a sufficient quantity of feces to 4 cc. and 9 cc. of distilled water in separate test tubes with graduations marked at 5 cc. and 10 cc., respectively. Mix well.

2. To 1 cc. of each dilution in each of 2 tubes, add 1 cc. of a 5 per cent solution of sodium bicarbonate followed by 2 cc. of a 7.5 per cent gelatin solution (Knox Gelatin—Johnstown, N. Y. Each envelope contains 7.5 Gm.), previously warmed to 37 C. Mix the contents well and place the tubes in a 37 C. water bath for one hour.

3. Transfer the tubes to an ice bath for 30 minutes. Examine.

Note: Prepare a control tube with all of the above ingredients except feces.

A rigid gel indicates no tryptic activity. Completely liquid contents are recorded as 4 plus.

B. Gelatin Film Test.—1. Prepare stool dilutions as mentioned above.

(Continued on page 514)

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Wisconsin's Stream Sanitation Program

Considerable progress has been made in Wisconsin toward eliminating stream pollution due to discharge of untreated sewage to our watercourses. At present, 90.7 per cent of the population provided with public sewers is connected to some form of sewage treatment plant. The minimum degree of treatment provided is sedimentation of solids. There are 236 sewage treatment plants in the state, serving approximately 1,800,000 people. Practically all of these plants have been built since 1920, indicating that the science of sewage treatment is a comparatively new one.

A considerable stimulus toward construction of these plants was the action of the State Board of Health and the Committee on Water Pollution beginning in 1932, initiating basin clean-up programs. Under these programs the state was divided into 28 drainage basins and the communities in each area were advised at meetings of officials that all were expected to do their parts in effecting a clean-up of the bodies of water on which their towns are situated. Dates were set when plans for treatment plants should be completed and construction started. This action, together with the public works programs in force during the 1930's, resulted in construction of many of our modern sewage treatment facilities.

At the present time, there are still 55 communities in the state which discharge untreated sewage to our lakes and streams. Some of these have constructed intercepting sewers to convey the sewage to a central point for treatment but have not yet started construction of the treatment works. Others now have sewage plants in the planning stage.

Pollution of our watercourses by sewage has serious consequences. The most important of these is the public health problem involved. Twenty-eight of Wisconsin's communities, comprising 32 per cent of the population, derive their source of water supply from lakes and streams. It is apparent that for these towns the discharge of raw or ineffectively treated sewage near the source would increase the problem of providing safe community water supplies.

Aquatic life in watercourses is adversely affected by sewage pollution, since the sewage solids in the process of decomposition tend to rob streams of oxygen, which is necessary to support fish and other life. Many areas in Wisconsin depend for their livelihood on the recreational uses of lakes and streams. Tourists bring millions of dollars to the state yearly. Pollution of natural waters can interfere with fishing, bathing, and other recreational uses which are so important in Wisconsin.

Agriculture is involved in this problem, since pollution may render natural waters unfit for stock-watering purposes and irrigation. Unclean waters decrease the value of nearby property both for residential and for commercial purposes. Aquatic nuisances prevent enjoyment of living quarters, and industries cannot use the natural water supply where pollution exists.

Local support for installation of essential treatment facilities is needed in those communities where raw sewage is still discharged to streams. Conferences have been held with 30 of the 55 communities that need treatment facilities and the remaining 25 will be contacted before the end of the year. With the completion of adequate facilities in these municipalities and the careful operation and maintenance of existing plants, we can expect that pollution of streams by raw sewage will become a minor problem and that existing public health hazards from this source will be reduced to a minimum.—THEODORE F. WISNIEWSKI, *Director, Division of Water Pollution.*

NOTES ON CLINICAL PATHOLOGY

(Continued from page 513)

2. Place 1 large drop on an unexposed, unfixed standard gelatin x-ray film. Clip the film to cardboard to prevent curling.

3. Incubate the film at 37 C. for one hour (one and one-half to two hours if room temperature is used).

4. Wash the film in cold water with gentle rubbing.

A clearing at the site of the drop indicates enzymatic activity. Complete clearing is designated as 4 plus and a slight clearing, only at the periphery of the drop, as 1 plus. Drying and caking of the material results if the drop is too small or if the concentration of the specimen is too great.

Proper bacteriologic precautions should be taken when dealing with cases suspected of enteric infection.

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Proceedings of the Milwaukee Academy of Medicine April 18, 1950

Diseases of Adaptation*

By HANS SELYE, M. D.
Montreal, Canada

THE diseases of adaptation are generally considered those in which there is an extreme reaction of the organism or certain tissues to a particular situation which might be called "stress." The condition is, therefore, analogous to what is known as hypersensitivity states. For an example, of 2 individuals exposed to pollen of ragweed, 1 may show no objective or subjective findings; whereas, the other may have violent tissue reaction of the nasal membranes. The individual with the tissue reaction expresses the stage of "resistance" to a stress.

Under the influence of systemic stress occasioned by a variety of nonspecific agents (most unpleasant but some may be pleasant), the organism responds with a general adaptation syndrome, the manifestations of which are entirely independent of the nature of the stress. The manifestation, however, depends mainly on the degree and duration of the exposure to the stress. The syndrome has three distinct stages: first, the *alarm reaction*, second, the *stage of resistance*, and, third, the *stage of exhaustion*. Hypertension is an example of the stage of resistance.

The mechanism by which stress produces an adaptation syndrome may be expressed as follows. A variety of nonspecific stresses elicit certain metabolic changes that may be called "catabolic impulses," which are particularly prominent in the alarm reaction phase. The catabolic impulses, in turn, influence the anterior lobe of the pituitary to produce an excessive amount of adrenal corticotrophin. This substance, in turn, causes the increased production of corticoid hormones by the adrenal. The corticoids then produce involution of the thymus and lymph nodes and also influence metabolism, namely, in reference to the retention of sodium and gluconeogenesis from protein. The corticoids, also through their metabolic action, cause a renal type of hypertension that is characterized by the morphologic picture of advanced nephrosclerosis. Obviously, during stress, sympathetic stimulation produces liberation of adrenalin and perhaps the pituitary also produces vasopressin, which likewise may contribute to the elevation of blood pressure. The adrenal corticoids may be divided into the glucocorticoids (cortisone) and the mineralocorticoids (desoxycorticosterone acetate or DCA).

The syndrome of adaptation and its salient points are given in further detail below.

Stress

Dissimilar nonspecific damaging agents produce a metabolic impulse characterized by the breakdown of body proteins accompanied by loss of weight and by histologic evidence of general cellular breakdown. This apparently is associated with increase in the concentration of protein catabolites and proteolytic enzymes in the blood. While these changes are going on, the typical "alarm reaction" which is characterized by adrenal cortical enlargement, gastrointestinal ulcers, and involution of the lymphatic organs develops. Prolonged stress, therefore, which is associated with adrenal cortical enlargement and increased corticotrophin (mineralocorticoid) production can produce nephrosclerosis and hypertension, particularly in sensitized animals with unilateral nephrectomy on a high sodium high protein diet.

Catabolic Impulse

Stress elicits a catabolic impulse characterized grossly by loss of weight, histologically by cellular degeneration and death, and biochemically by an increase in the blood in proteolytic enzymes and protein breakdown products. At the same time there are hyperkaliemia and possibly a rise in the blood concentration of histamine or "H substance" in addition to hypochloremia, hypothermia, a decrease in blood pressure, gastrointestinal ulcers, and hemorrhages. These manifestations are especially prominent in the alarm reaction. The catabolic blood changes increase mineralocorticoids during the period of stress.

Hypophysis

The hypophysis is essential in this type of reaction, since hypophysectomy prevents the production of hypertension by stress. This implies that increased hypophyseal activity causing corticotrophin production is essential for resistance to stress. Hypophyseal extracts which are rich in corticotrophin cause adrenal cortical enlargement, hypertension, sclerosis, and thymicolymphatic involution in animals with normal adrenals.

* The complete paper by Doctor Selye is available from the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3.

Adrenals

Intact adrenals are also necessary for the production of the syndrome, since adrenalectomy prevents the involution of thymic and lymphatic organs. In adrenalectomized animals more than the maintenance dosage of corticoids must be administered if the animals are to withstand stress; therefore, increased cortical function is an essential part in the defense reaction against stress. Since high doses of the mineralocorticoids produce all of the changes mentioned previously, it is presumed that the increased production of such corticoids during the adaptation syndrome can cause the sclerosis and hypertension.

Kidneys

Hypotension occurring in a shock phase may show decrease in the blood pressure and the blood supply of the kidney, causing increased renin production. Administration of DCA causes hyalization of individual glomeruli and thus diminishes the blood supply so that individual nephrons may become "endocrine-nephrons." By endocrine-nephron or kidney is meant that the kidney or its nephrons have their blood pressure reduced to the colloid-osmotic pressure of blood under which conditions filtration of plasma and urine production cease and the architecture of the kidney becomes completely altered and hardly recognizable. This type of kidney produces the hypertensive substances. In the endocrine kidney there is active proliferation of the tubular cells with loss of eosinophilic granules and brush border of the convoluted cells and the complete disappearance of recognizable tubular lumens and glomeruli. In general, therefore, one great factor in the production of the diseases of adaptation is the excessive formation of mineralocorticoids which influence sodium and protein metabolism and are particularly characteristic of the syndrome of hypertension. On the other hand, the glucocorticoids (cortisone) are antagonistic to the effects of the mineralocorticoids. Stress changes as well as the effects of DCA administration are adequately treated and are usually prevented by the administration of cortisone. Such animal experiments led to the consideration that many of the human diseases—malignant hypertension, arthritis, or collagen diseases—are those of the alarm reaction which continue into the second stage of resistance and finally into the stage of exhaustion. Furthermore, the clinical use of cortisone or ACTH, which causes increased production of cortisone, seems to corroborate this concept.

AMERICAN COLLEGE OF PHYSICIANS OFFERS RESEARCH FELLOWSHIPS

The American College of Physicians has announced that a limited number of fellowships in medicine will be available from July 1, 1951 to June 30, 1952. These fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in internal medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities for the proper pursuit of his work.

The stipend will be from $2,200 to $3,200.

Application forms will be supplied on request to the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania, and must be submitted in duplicate not later than October 1, 1950. Announcement of awards will be made in November 1950.

. . . . The President's Page . . . .

Faith, Hope, and Charity

PLEAS for better care for Wisconsin's ailing old folks have again been made to the state legislators, this time at a hearing called by the Legislative Council.

It is significant that this concern over the welfare of the aged and chronically ill has expressed itself from within the Capitol halls. For the past two sessions of the legislature, the State Medical Society of Wisconsin has entered bills to encourage the erection of county infirmaries for the aged. Physicians, judges, and public welfare and county board officials have been keenly aware of the problem. Now the Legislative Council, chief interim body of the lawmakers, has recognized the problem of providing for a population that is growing old.

A single hearing doesn't mean that the solution is in sight. There are many snags—not the least of which are money and complicated, conflicting county, state, and federal laws. But the recent hearing should be a reassuring note to thousands of Wisconsin aged who now must be labeled "crazy" before they are eligible to receive even the barest necessities for life in their declining years.

In the sea of uncertainty which surrounds the aging citizen of Wisconsin and confounds the legislators, the words of Colby's Dr. H. H. Christofferson, chairman of the State Medical Society's Committee on Mental Hygiene and Institutional Care, stand out like a beacon light:

"The problem of the aged and chronically ill is too vast in its entirety to suggest an immediate or complete solution. The present program is both inhumane and unprepared to meet a problem which is growing in scope and intensity with each year that passes. But let us begin where the need is greatest—that of giving the old people of this state better treatment than committing them to our already over-crowded mental institutions.

"They deserve more out of life than to end it with those unfortunates who have lost their reason and can offer little or nothing by way of companionship.

"Meeting this problem will command courage. Even a modest start will cost money, but let us meet the situation with honesty and take the problem to the people. We believe that our citizenry is too enlightened to refuse support if this program is properly presented."

The legislators have recognized the problem. The State Medical Society, along with judges and public welfare and county officials, points the way to part of the solution. To the aged, fearful of being abandoned after a full and useful life, these actions restore faith in the goodness of men, renew hope of happy, enjoyable years ahead, and re-establish charity as the greatest and most noble virtue.

John Wm Truitt MD

Industry Looks at the Doctor*

By B. A. KRAWCZYK
Milwaukee

B. A. KRAWCZYK

Supervisor of the compensation department of Allis-Chalmers Manufacturing Company, Mr. Krawczyk was admitted to the Wisconsin Bar following his graduation from the Marquette University Law School in 1937. He is a member of the Wisconsin State Advisory Committees on Unemployment Compensation and Workmen's Compensation and serves as chairman of the Social Security Committee of the Wisconsin Manufacturer's Association.

IN THE early days of this great nation, it was, for the most part an agricultural country. At that time there was a "land" economy. On their land and in their homes the farmers produced virtually everything they needed and thereby provided their own security. Young and old shared in the work and earned a place at the family table; and, so the father's death did not mean economic disaster. There was still the farm, which yielded a living to the widow and the children.

On the farm the old folks generally continued to earn their living until they died. When the farmer's strength no longer matched his son's, his judgment and experience still had made him a valuable addition. As for the grandmother, even with failing strength, there were many household tasks she could do.

At that time people practiced medicine themselves, by the use of "home remedies" taught them by their elders. A doctor, if there was one, was called only when it was apparent to the people that the "home remedies" did not aid the patient. For the most part, the doctor was paid for his services by things in kind.

As time went on, commerce took hold, and small towns and villages arose. People from the farms began to drift into these small towns and villages, and with them, of course, came the doctor, the lawyer, and other professional groups. As commerce and industry progressed and expanded, opportunities in the small towns and villages began to grow. These towns slowly became large cities, and with this trend the people built hospitals, established schools, and sponsored other services required by the community.

During this transition (migration from the farm to the city) this country took on a different kind of economy—the "money" economy. The people worked, performed services, and sold these services to others, who paid for them in currency, which in turn "bought" their necessities.

With this country's transition from the "land" economy to a "money" economy, problems arose. Under the "land" economy the people made their own security. In the "money" economy people began to depend on someone else for their security. People became injured while on the job and sought their remedy at common law by suing their employer in a civil suit. Unemployment resulted from time to time. People became ill and were faced with a loss of income together with expenses for hospital and medical treatment.

With industrial ingenuity and skillful engineering, industry has steadily developed. With this rise of industry, employees slowly began to organize in order to enable them to bargain for their rights. With the adoption of the National Labor Relations Act in 1935, employees were encouraged to organize and large labor organizations were founded. Today, our farm population is only 20 per cent of our overall population. Today, the balance of our population is divided into groups, consisting of the working man, business man, lawyer, doctor, nurse, engineer, accountant, etc. All of these groups are today struggling for their own existence.

And so today, having accepted the "money" economy, each group finds that it has problems from within as well as without. As to its internal problems, each group usually finds a solution within the normal functions of its own organization. External problems, by nature interrelated, can be resolved only by the full cooperation of each group as the only antidote to rugged individualism. In the absence of cooperation and mutual assistance, each has to a great degree gone its separate way, with the inevitable recourse to government, the third party.

Before the turn of this century, two of these groups, industry and the doctors, had very little contact with each other. There were several industries and some doctors before the turn of the century who realized their obligation to society and to the working man and established "mutual aid society plans," under which employer and employees both contributed a certain amount for the payment of hospital and medical expenses.

I should like to point out to you, by historical review, how the advent of social legislation enabled industry and the doctor to join hands in the common cause of alleviating human suffering and misery.

* Presented before the Industrial Clinic of the State Medical Society of Wisconsin, Milwaukee, May 3, 1950.

Wisconsin Workmen's Compensation Law

As a matter of fact, the first step took place right here in the state of Wisconsin in 1911. In that year the first state Workmen's Compensation Law in the United States was enacted.

Under the provisions of this law, an employer became liable to his employees who were injured during the course of their employment, for hospital and medical expenses as well as a weekly indemnity, irrespective of whether there was negligence on part of the employee or the employer. As time went on, employers began to take note of the cost of this program and took steps to minimize it.

It was logically reasoned that, in order to cut the cost of workmen's compensation, an attempt must be made to prevent accidents. Thus was born the "safety movement" in the United States. This movement continued to grow, so that today every employer places real emphasis on safety activity within his plant.

The doctors play a prominent role in the administration of this law. It is to the doctor that injured employees are referred by employers for treatment, rehabilitation, and eventual return to work. In the field of workmen's compensation, industry relies heavily upon the doctors and the nurses. Industry desires that its injured employees receive the best medical treatment possible and expects the doctors to provide such treatment. Industry is obliged to pay for these services at *reasonable rates*. Likewise, industry is desirous that estimates of permanent disability be made without bias or prejudice and that these estimates be fair to the injured employee. Unbiased and unprejudiced judgment must be used in determining causation and the ferreting out of malingerers.

Wisconsin's Workmen's Compensation Law has been successfully administered by our State Industrial Commission since its very beginning. The law has been extended, expanded, and improved, so that Wisconsin today, having taken the first step in this field, is still at the top-as compared with other states.

Unemployment Compensation

Industry and the doctor had nothing to do with each other in the field of unemployment compensation until 1945, when the state legislature adopted a provision allowing benefits to an individual who leaves his job voluntarily but for a compelling personal reason. This clause, for the most part, allows benefits to employees whose health would be impaired or would progressively deteriorate if they continued at the job to which they were assigned. All that is necessary to qualify the individual for benefits is to present to the unemployment compensation division a statement from the doctor showing that his health was such that he could not continue on that job. In some instances, industry has found that the reasons given by the doctors are not in accordance with the real situation. In some of these cases industry has found that the doctors issue the certification without a full appreciation of the job incidents and their possible effect on the *alleged* physical condition.

Verified Medical Reports Under Workmen's and Unemployment Compensation Laws

Provision appears in both the workmen's compensation and the unemployment compensation laws for the filing by the claimant of a verified medical report completed by the doctor and notarized. These verified medical reports are to be used *only by the employee*, and only in the event that there is contest and a hearing is to be held. Verified medical reports must be filed with the Industrial Commission at least within 15 days before the hearing is scheduled. Under law, a properly completed verified medical report will serve as prima facie evidence of its contents. If such verified medical report is presented to the Commission, the physician need not appear at the hearing unless the insurance company or the self-insurer is desirous of cross-examining the doctor. In such latter instance, the doctor's fees for his appearance and testimony must be paid by the insurance company or the self-insurer.

I bring this matter to your specific attention at this time, because the use of these verified medical reports, on behalf of the claimant, serves the purpose of carrying out the spirit of the laws. It provides prima facie medical testimony for the claimant without the employee's incurring the expense of the doctor's personal appearance.

Weekly Cash Disability Benefits

Weekly cash disability benefits is a new field of social legislation. The states of Rhode Island, New Jersey, New York, and California have already passed such laws. Bills on this type of legislation are being presented to practically every state legislative body.

In the state of Wisconsin, at the last legislative session, three such bills were introduced. The first bill was the Laird Bill, which excludes the state from the funding program and provides that the hazard be met by insurance, whether purchased or self-insured. The other two bills, sponsored by the CIO and the AFL, propose a state fund to which the employer and employee would be obliged to contribute.

If a law is enacted, you, as doctors, will be immediately involved with its operation.

For a considerable period of time the Federal Security Agency has had a bill (H.R. 2893) in draft form which, among other social security revisions, would place cash disability benefits on the same compulsory basis as unemployment compensation benefits. This bill, motivated by the President, was considered by the House Ways and Means Committee during the greater part of the year 1949. The committee finally substituted Bill H. R. 6000,

likewise a social security revision bill, and reported it out of committee with no provision for cash disability benefits.

Federal Social Security Law

While the federal social security law in its entirety does not have any direct reference to the doctor, some brief comments on the subject appear to be justified so that the pattern of welfare trends may be completely understood and evaluated.

The law was passed in April 1935. It is an omnibus law. It provides for the federal Unemployment Tax Act, pensions to those 65 years of age or over, public assistance to the needy aged; aid to the blind, and aid to dependent children. It also includes children's services, maternal and child health services, and services for the crippled children.

Bill H. R. 6000 amends the present law. It passed the House last year by a huge majority and is now in executive session of the Senate Finance Committee, after lengthy hearings from January through March of this year. It is expected that the bill will be reported out of committee during this month. The bill calls for an extension of coverage and substantial increases in retirement benefits and also makes provisions for additional public assistance.

Old age has become a serious problem in America. We are no longer a nation of young people. Because of the advances of medical science and other factors, we are, relatively speaking, becoming a nation of older people. In 1860 there were about 800,000 persons 65 years of age or over; by 1900, 3,000,000; by 1940, 9,000,000; and it is estimated that there will be, roughly, 21,000,000 persons 65 years of age or over by 1980. Here is a serious problem which arose with our transition to a "money" economy.

The national planners favor increased benefits far beyond the basic needs level with an increasing rate of payroll tax.

Pensions are good; they are desirable in themselves, but the fact we must all face is that our economy cannot support these tremendous financial burdens of providing higher and higher benefits without handicapping industry, and reducing too much the standard of living of those currently employed, whose wages become the source of taxes to support the pensions of those who have retired.

National Health Insurance

Now let us turn our attention to national health insurance. Under the private enterprise system, we have the highest standard of medical and hospital care in the world. While the United States has only 6 per cent of the world's land and 7 per cent of the world's population, it does, nevertheless, have 50 per cent of the hospital beds. It has 140 doctors per hundred thousand population. This compares with 114 in England, 103 in New Zealand, 75 in France, and 4 in China.

Over 60,000,000 Americans have voluntarily subscribed to private medical and hospital insurance. This is a voluntary insurance plan in the field of private initiative. It is the American way. Yet, despite this, there are the seeds of discontent with present medical services being spread among the American people. And why? Because medicine is not free from criticism. Voluntary insurance has not been more widely used, and to some extent you as doctors are to blame for this condition. Because of your past attitudes, people believe that they are being charged more than a reasonable fee both for medical and for hospital care. While there may be isolated instances which substantiate their complaints, they do not represent the real reason. The remedy for this condition, though the hour is late, *is constructive action on your part.* This constructive action must come from the standpoint of conscientiously providing the finest medical care for the lowest possible cost. It must come from the promotion of constructive insurance plans. It must come from the adoption of a public relations program which will point out the evils of compulsory national health plans, on the one hand, and, on the other hand, solicit patients in the normal development of the only plan, private medicine, which will ultimately benefit all people.

Now, let us frankly discuss the alternatives— compulsory national health insurance or voluntary plans, —so that in being better informed you may become effective instruments in this constructive approach to which I have referred.

Compulsory National Health Insurance

Compulsory national health insurance should be opposed for economic as well as technical reasons. It should be opposed on an economic basis, because it would impose a payroll tax of 6 per cent on incomes up to $4,800 per year—a tax of $288 equally shared by the employer and the employee. A self-employed person would be required to pay the entire 6 per cent.

Experts still cannot estimate what the total cost of the plan might be. England could not estimate the cost of its socialized medicine program either. Its proponents said that it would be 150 million pounds the first year—the cost was actually 300 million pounds—a 100 per cent increase.

It should be opposed from a technical or service viewpoint, because we need only look at England to see what socialized medicine has meant in the lives of the British people.

It has revolutionized the status of the doctor and patient. It requires a doctor, under the plan, to treat 4,000 patients per year in the industrial areas and 2,500 in rural areas. It is obvious that this results in mass impersonal treatment. Free medicine has also caused a flooding demand for treatment of minor illnesses which would have been relieved by "home remedies." Up to November 1949, there were 200,000 people in England who required operations, and, although there were 57,800 empty hospital beds,

there were not enough doctors or nurses who voluntarily came under the plan. And why? Because, three weeks after the British bill passed Parliament, the minister of health issued a statutory instrument, No. 506., "terms of service." This makes the records of the patients and the type of treatment rendered available to local lay counsel. This practically invalidated the Hippocratic oath. It seems obvious that conscientious people will not devote their lives to a profession as sacred and intimate as medicine under circumstances which render the oath which they take a mockery.

The low ebb of British medicine was again brought to our attention recently when Dr. Ralph J. Gampell, who emigrated to America from Britain, spoke at the 1949 State Welfare Conference in Milwaukee. I should like to quote from Doctor Gampell's published remarks ". . . socialized medicine took from the doctors their freedom. After it was instituted, he said, 'I found myself with 3,200 patients. I made as many as 36 house calls a day and was able to average only 3 minutes per patient in the office.' For surgery termed 'elective' Dr. Gampell stated there was a waiting list of three years at his local hospital. Patients had to wait 8 weeks before they could see specialists at the hospital. Under medical regulations, he declared bald men were not given one toupee but two toupees free, one to be used when the other was at the cleaners. For a population of forty-five million people, fifty million pairs of spectacles were issued." This, I believe, is enough for socialized medicine in Great Britain.

Now then, what are the American national planners proposing in this country? The administration has had introduced three companion bills. They are S. 1679, H. R. 4312, and H. R. 4313, whose provisions are discussed in a pamphlet published by the Wisconsin Chamber of Commerce.

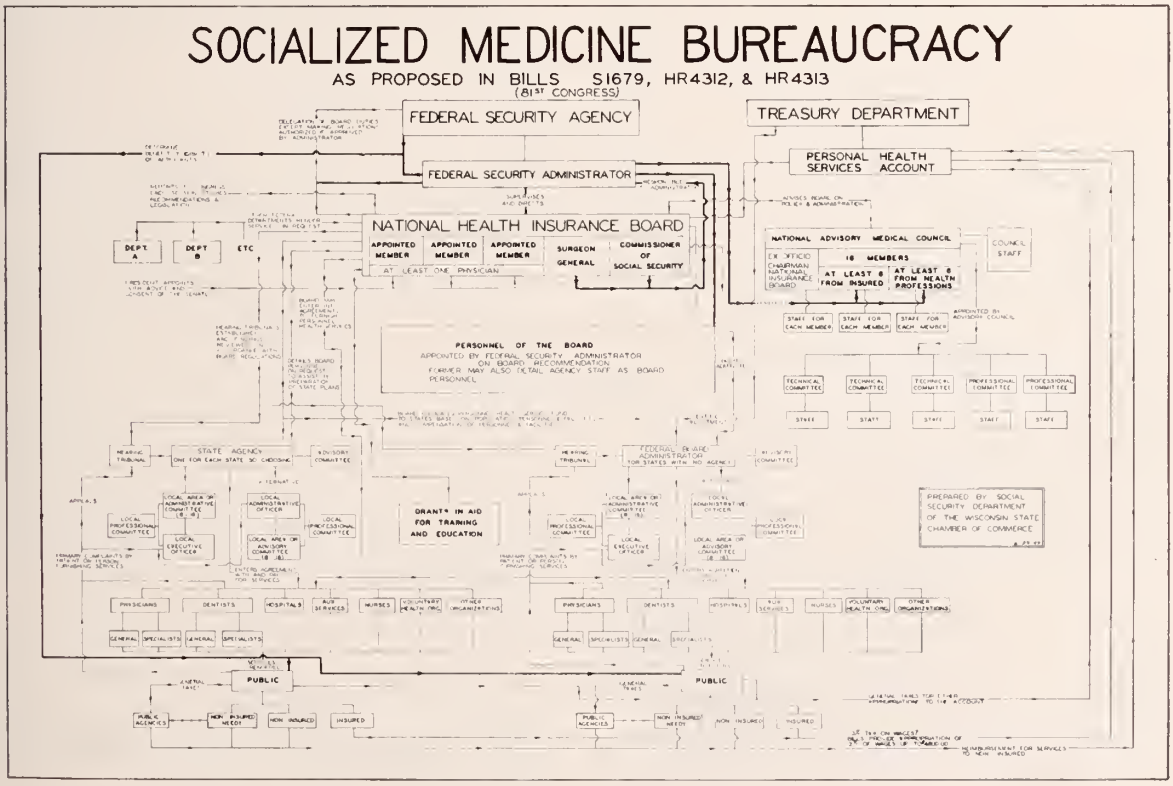
Below is the chart contained in this pamphlet,* which shows the complexity of the operation of the plans set forth in these bills. Rough estimates are that the services of 250,000 people will be necessary to administer this program.

National planners have said that the health bills of the administration, charted below, contain measures to curb the evils of the British system. I leave it to your judgment. I am not convinced.

Financial Aspects of Social Legislaiton

A survey published by the Brookings Institution in the early part of this year on "The Cost and Financing of Social Security," shows the estimated aggregated cost of major social security programs and veterans' benefits, from the year 1960 to the year 2000. These estimates include all benefits under H. R. 2893 (H. R. 6000 was not available at the time of this survey): temporary disability, compulsory health insurance, unemployment compensation, public assistance, and veterans' benefits. The cost estimate for 1960 varies from a low of $21 billion

* Copies of this pamphlet may be obtained by writing to the Wisconsin State Chamber of Commerce, 119 Monona Avenue, Madison 3, Wisconsin.



to a high of $35 billion; for the year 2000 from a low of $32 billion to a high of $55 billion.

Let us be realistic for a moment. Our current national budget is $42 billion, with an estimated deficit, adjusted by actual expenditures, of over $6.5 billion. Now here is my point. The estimated expenditure of $21 to $35 billion (1960) is one half to over three fourths of all present revenue from taxes—corporations, income, excise, and customs. Are we willing to vote an increase of 50 to 100 per cent in taxes to pay for these welfare schemes, or are we agreeable to having the government continue a deficit spending program to ultimate national bankruptcy? I do believe that welfare measures are good and desirable if supportable by the economy. It should be amply clear that as yet we do not have the wealth-producing power to support these dreams.

Voluntary Health Plans

This is purely and simply a question of social responsibility. It implies responsibility on the part of an employer, whether private or public, as well as the individual to join in insuring themselves against the cost of illness. Most companies have already faced up to their responsibilities by the institution of company plans; others have joined with employees in purchasing insurance—Blue Cross, Blue Shield, and others—and, finally, millions of others have purchased insurance on their own initiative.

Government efforts should only be subsidiary and supplemental to these plans and efforts.

I should like to acquaint you with the splendid work which has been done by the Medical Society of New Jersey under the leadership of Dr. James F. Norton of Jersey City, president of the New Jersey State Medical Society and vice-president of the American Medical Association. Their 12 proposals are constructive and without urging should constitute a *must* on your individual and group reading and study programs. (The full New Jersey Plan is printed after the conclusion of this paper.)

This plan, as its sponsors suggest, "invokes for government, less action, responsibility, and authority than any other National Health program suggested by any legislator or as yet evolved by any agency within the Medical profession. The Medical Society of New Jersey readily admits—in fact, we assert that—this program is neither final, complete nor undebatable. But it is, at least, a beginnin."

In conclusion, I believe, that the medical profession is guilty of the same fault which has afflicted industry—a negative attitude.

The American people have gone farther down the road in their acceptance of government proposals for national health insurance than we are willing to believe. You argue that it is another step toward socialism—but your logical arguments of lower standards of medical and hospital care will convince but few.

The responsibility of leadership in matters of medicine rests squarely on your shoulders and conscience. Why not wage intensive campaigns to convince people to insure against sickness loss by voluntary insurance as they would insure any other common hazard? Why not underwrite fact-finding committees to study how voluntary insurance might be made to give more protection? Why not develop ways and means of bringing better medical care to marginal regions?

If you fail in this duty of community and national leadership, the government will do the job, and both you and your patient will suffer, but most of all—and what is more important—our national economy will suffer.

I have deliberately refrained from picayune argument and circumstances which may or could come up in the day to day relationship of industry and the doctor. As a representative of industry, I have preferred to discuss the philosophy of Americanism and the aspects of economics which if well employed and dispatched, will enable both of us to fulfill our greatest opportunity—leadership.

New Jersey Reprint

Proposals of the Medical Society of New Jersey For a National Health and Medical Care Program*

A twelve point "cooperative health program, in which national and state governments may participate without endangering individual initiative, personal freedom or scentific progress" was set forth on January 30, 1950, by The Medical Society of New Jersey.

The program was revealed by Dr. James F. Norton of Jersey City, President of the State Medical Society and Vice President of the American Medical Association. In introducing the Medical Society's proposals, Dr. Norton said:

"We believe this positive cooperative health plan constitutes a 'standard to which all men of good will can repair'. We propose to seek endorsement and active support of this program from every private and public organization in the community.

"We are convinced that people working together can solve their social problems, acting through the many voluntary organizations that already have accomplished so much in making life safer, healthier and happier for everyone.

"Government—local, state and national—has a part to play, but it should seek to promote and supplement the efforts of free citizens, not to supplant or supersede those efforts. We have tried in this statement, to define the proper role of government and to show how voluntary agencies, including the medical profession, can exert the leadership that the public expects of us."

Text of the Society's statement follows:

The Medical Society of New Jersey favors, and always has favored, a constructive approach to the

* A statement, published January 30, 1950 by James F. Norton, M.D., President of The Medical Society of New Jersey, and as authorized by the Board of Trustees of The Medical Society of New Jersey. Copies available on request.

solution of the national health problem, particularly as it applies to the citizens of New Jersey. The solution of medical and health problems should be undertaken in a realistic, scientific spirit. Moreover, since the health of the people transcends all political considerations, it must be considered on a non-partisan basis.

In view of the fact that the Congress of the United States and the state legislatures are considering various extensions of the health program, the Medical Society believes that the following statement presented as a definite and comprehensive program of action, will be helpful at this time.

The Medical Society of New Jersey believes there are large areas in which government may beneficially cooperate with the citizens, individually or acting through voluntary associations, in furthering a health program—in the interest of all the people, and without jeopardy to individual liberty. It is generally recognized that voluntary cooperative effort should have priority at all times. Government should seek to promote and supplement the efforts of free citizens, (not to supplant or supersede voluntary action) whenever voluntary cooperative effort can meet the need.

Any constructive approach to solution of the health problem must take into account the several classifications of those who require medical care, namely:

1. Those not employed, but able to sustain the full cost of providing for hospital and medical care.
2. Those who are employed.
3. The "medically indigent", whose income does not suffice to meet the costs of catastrophic illnesses.
4. The totally indigent, who are on public assistance rolls.
5. The chronically ill.

Any adequate program to meet health needs should include medical and hospital care. Insofar as possible, such care should be so inclusive that everyone may budget in advance against the financial burden of sudden illness. In addition, the program should assure every community of basic health protection through well-organized professional public health departments.

No matter what program is devised, it should be experimental, flexible and evolutionary in character. It should be sufficiently concrete as to be readily understood and practically adaptable everywhere.

The Medical Society of New Jersey, therefore, offers the following proposals for a cooperative health program, in which national and state governments may participate, without endangering individual initiative, personal freedom or scientific progress. The sequence in which this program is set forth does not necessarily indicate the relative importance of its parts.

1. Voluntary non-profit organizations should be used as the best means of budgeting hospital and medical service for the individual and his family.

(a) The Blue Cross movement, providing for hospital care on a non-profit, minimum cost basis, is recognized as the outstanding development in this direction. First established in New Jersey less than twenty years ago, Blue Cross has extended to nearly every part of the United States. There are now 96 Blue Cross organizations with a combined enrollment of more than 35 million people. In New Jersey, approximately one-third of the population now enjoys this protection.

(b) The Blue Shield movement, launched within the past decade, has made possible the prepayment of medical care on a budget basis, which in some areas means that the doctor's bill for eligible care is covered in full for 80% of subscribers and their dependents, of whom there are now more than 12 million persons enrolled throughout the United States. Blue Shield in New Jersey has enrolled 350,000 people in only seven years.

2. For persons not employed, but able to meet the cost of enrollment in such voluntary non-profit organizations, we propose that the premiums be made eligible for deduction for income tax purposes, regardless of the financial status of the subscriber or the amount of the premium paid.

Such deduction is equitable, inasmuch as employers who pay or contribute to the enrollment cost for their employees are already permitted to deduct these costs for income tax purposes, in cases where the latter enters into the computation of Federal income tax.

3. For employed groups, it is encouraging to note the growing practice of the employer contributing toward the cost of health and welfare programs for his employees and dependents. As mentioned, such payments are usually tax-deductible as part of the cost of production, and are being increasingly recognized as a legitimate part of that cost.

4. As an immediate encouragement toward employer contribution toward the enrollment cost of hospital and medical protection, government, at every level from municipal to national, should promote the program of such protection for its own employees, by assuming either a part or all of the cost of enrollment in voluntary prepayment plans.

5. As rapidly as possible, consistent with actuarial experience and sound administration, the services eligible under such voluntary non-profit organizations should be extended to cover all non-chronic ailments on an inclusive basis. An encouraging step in this direction is the decision of the Blue Shield Plan in New Jersey to provide complete coverage (within the $5000 annual income limitation) for maternity services, including delivery and pre or post-partum care, in the hospital, the home or the physician's office.

6. After sufficient enrollment is attained, we recommend that consideration be given the practicability of providing medical care protection on an inclusive basis to subscribers in voluntary, non-profit plans, regardless of the financial status of the subscriber, and with no salary limitation for over-all inclusive service.

7. We propose that immediate study be given the possibility of providing voluntary, non-profit protection for those who are "medically indigent" though not on public assistance rolls, through the use of state and local funds for the purchase of such protection. As a rule of thumb to determine "medical indigency", the criterion might be the question whether one's taxable income is such as to exempt him from payment of Federal income taxes.

8. For the medical and hospital care of persons on public assistance rolls, we recommend the providing of service through state-county-municipal funds, with such Federal aid as may be found necessary or may be provided from time to time, perhaps utilizing on a cost basis the voluntary non-profit organizations for the actual provision of the required services.

9. There is no actuarially sound basis yet established for treating the chronically ill as an insured group. We suggest, therefore, that study be given to providing care for needy persons suffering from chronic illness, on a cost basis at State level, again with the possibility of utilizing the facilities of voluntary non-profit organizations.

10. The need for better local public health service in most areas of the United States has long been recognized, but progress in providing it has been discouragingly slow. We recommend that every state government—particularly our own in New Jersey—adopt such legislation as may be needed to permit consolidation of local health jurisdictions into districts having sufficient size and resources to support at least a minimum staff and facilities for complete modern basic public health protection.

11. There are numerous areas in certain states where the private practice of medicine is economically or professionally impractical, because the areas will not sustain a sufficient number of capable physicians on a fee-for-service basis, or because hospital facilities are inadequate or lacking. Progress is being made under the Hill–Burton Hospital Survey and Construction Act toward meeting the deficit of hospital accommodations. We suggest exploring the possibility of the U. S. Public Health Service providing competent physicians to such areas when requested by State or local agencies.

12. Such a cooperative health program as is here envisaged may require a considerable increase in the number of physicians, health officers, nurses and other medical personnel. Ideally, every qualified person desiring to enter the field of medicine and public health should be able to do so. We support a program of government subsidy, where needed, to assist qualified individuals in obtaining professional training and to expand professonal training facilities where it is found possible to expand existing schools or to establish new ones. In this connection we renew our plea for early action looking toward establishment of a medical school in New Jersey. We believe that any governmental subsidy that may be provided for these purposes should be granted unconditionally to approved institutions.

The Medical Society of New Jersey submits that through such voluntary cooperative action, the problem of attaining an adequate national health program can and will be solved. This suggested program is not intended as a nebulous proposal for the indefinite future, but might well be inaugurated within the present year.

Introducing the Guest Editorialist

Dr. Harvey M. Uebele, Milwaukee, is the immediate past-president of the Wisconsin State Dental Society.

Doctor Uebele graduated from the Northwestern University School of Dentistry in 1908. For 27 years he served on the faculty of the Marquette University School of Dentistry.

During the 42 years in which he has been in practice, he has written innumerable papers on various dental subjects, principally on "Porcelain Restorations," in which he pioneered. He has served on many state and local committees and held various offices, including the presidency of the Milwaukee County and the Wisconsin State Dental Societies.

In addition to being a member of the several prominent national dental organizations, Doctor Uebele holds membership in Delta Sigma Delta and Omicron Kappa Upsilon.

Dentistry and the National Scene

A REQUEST for a guest editorial came to me immediately following the completion of my term as president of the Wisconsin State Dental Society, at a moment when I was particularly cognizant of the mutual problems facing the health professions. Many of the important issues which confronted our organization were duplicated the country over in local, state, and national dental and medical groups.

The dental profession has been vitally concerned with striving to keep the important job of treating the sick and improving the health of the population from becoming the football of politics. Merely telling people that socialized medicine is not good for them is not going to stop social planners from trying every scheme at their command to put over an arbitrary "new deal" in health. We should never lose sight of the fact that it is generally a *hard working minority* that effects changes of this type, by intimating to the lay people that they are going to receive all-inclusive services "free" or at the expense of that elusive entity, "the government."

To combat a well organized minority, you must have a more efficiently organized and harmonious majority. A united front of the part of the physicians, dentists, nurses, hospital administrators, and others sincerely convinced that "compulsory health insurance is not the answer" must be fostered and maintained.

The Wisconsin State Dental Society in its own limited sphere has informed the public as to what it can expect if a compulsory health insurance bill is passed. In common with other dental organizations, it has actively engaged in advocating a program of prevention as the first important step toward improving and maintaining the oral health of the people. Typical instances are the fluoridization of public water supplies, topical application of fluorides to the teeth of children, and proper mouth hygiene.

A comprehensive prepayment plan for dentistry, though it has received study, has not yet been evolved, principally because the profession has been old-fashioned enough to be intellectually honest and not promise more than it knows it can deliver. This is in sharp contrast to those ambitious legislators who deal in glowing generalities!

The dental payment plan of the Wisconsin State Dental Society has been evolved, and the mechanics of this postpayment arrangement are being perfected. It should appeal especially to those in the lower income groups who have accepted the American principle of instalment purchasing. It should also appeal to the many who would not avail themselves of a prepayment plan even if it were offered.

Numerous requests have been received by the profession from local and state organizations to help improve oral conditions. Only limited offers of assistance could be considered because, unfortunately, dentistry in many instances is not represented on state and local boards of health.

The full weight of dentistry will be increasingly felt on the national scene as the cooperation between medical and dental societies, now evident in so many instances, becomes truly universal, and the combined groups join in planning comprehensive health programs. Thus assistance would be available from the professions united, instead of lay social planners.

Harvey M. Uebele, D. D. S.

W. C. KEETTEL, M. D.

OB-Pediatric Clinics In North, July-August

The Bureau of Maternal and Child Health of the State Board of Health is pleased to announce the inauguration of a circuit clinic teaching program in obstetrics and pediatrics similar to that carried on so successfully in various northern communities before the war. The service is renewed at the request of many physicians who participated in the previous clinics.

Details of the program were being arranged at the time the June Journal was sent to the printer, and all physicians in the northern part of the state will be notified by direct mail concerning further details, as to meeting places and subject matter to be discussed. *If you have not received your notice by July 10 write the Bureau of Maternal and Child Health, State Office Building, Madison 2.*

THE FACULTY

OBSTETRICS:

WILLIAM C. KEETTEL, M. D.: Professor of Obstetrics, University of Iowa. Doctor Keettel was formerly associated with the State Board of Health in Wisconsin and is well known throughout the state for his skill in teaching.

JOHN MOORE, M. D.: Instructor in Obstetrics, University of Iowa. Doctor Moore is a graduate of the University of California Medical School, and was associated with Doctor Trout before joining the faculty at Iowa.

PEDIATRICS:

LEONARD WEINER, M. D.: Doctor Weiner is a graduate of the University of Wisconsin, trained in pediatrics with Doctor Poncher at the University of Illinois. Now at Yale University where he has been associated with Doctor Powers in pediatrics and with Dr. Milton Senn (a former Wisconsin resident) in the Child Study Center, he is highly recommended by both Doctors Power and Senn.

TENTATIVE SCHEDULE

PHILLIPS—MONDAYS

July 17: Doctor Moore
July 24: Doctor Moore
July 31: Doctors Keettel–Weiner
Aug. 7: Doctor Weiner
Aug. 14: Doctor Weiner

RICE LAKE—TUESDAYS

July 18: Doctor Moore
July 25: Doctor Moore
Aug. 1: Doctors Keettel–Weiner
Aug. 8: Doctor Weiner
Aug. 15: Doctor Weiner

SUPERIOR—WEDNESDAYS

July 19: Doctor Moore
July 26: Doctor Moore
Aug. 2: Doctors Keettel–Weiner
Aug. 9: Doctor Weiner
Aug. 16: Doctor Weiner

ASHLAND—THURSDAYS

July 20: Doctor Moore
July 27: Doctor Moore
Aug. 3: Doctors Keettel–Weiner
Aug. 10: Doctor Weiner
Aug. 17: Doctor Weiner

CHIPPEWA FALLS—FRIDAYS

(Eau Claire—Menomonie—Chippewa Falls Area)

July 21: Doctor Moore
July 28: Doctor Moore
Aug. 4: Doctors Keettel–Weiner
Aug. 11: Doctor Weiner
Aug. 18: Doctor Weiner

WATCH FOR DIRECT MAIL ANNOUNCEMENTS FOR FURTHER DETAILS

(Or, Write to Bureau of Maternal and Child Health, State Office Building, Madison)

F. W. MADISON, M. D.
General Program Chairman

Preliminary Announcement

1950 ANNUAL MEETING

DATES: OCTOBER 1-2-3-4 ★ **MILWAUKEE**

HOUSE OF DELEGATES:

First session will be held 1:30 p. m., Sunday, October 1, in the East Room, Hotel Schroeder

Second session: 6:00 p. m., Monday, October 2

Third session: 9:00 a. m., Tuesday, October 3

SCIENTIFIC SESSIONS:

General programs, clinical conferences and section meetings will be held in the Milwaukee Auditorium, starting Monday, October 2, at 9:00 a. m., and concluding with section programs Wednesday afternoon, October 4

ANNUAL BANQUET:

Tuesday evening, October 3, 7:00 p. m. Featured speaker will be announced later.

Program will include special awards to new members of "50 Year Club"

Reserve Your Rooms Early!

Hotel conditions are still crowded, so we urge you to make your reservations *early*. Rates of larger downtown hotels are given below. If you are unable to secure accommodations at the hotels listed, you may contact the Housing Bureau of the Milwaukee Chamber of Commerce.

Special Note to Delegates and Officers: The first session of the House of Delegates will be held on Sunday, October 1, so make your reservations accordingly.

Official Headquarters: Official headquarters are at the Hotel Schroeder, where luncheons and the Annual Dinner will also be held.

DOWNTOWN HOTEL ACCOMMODATIONS AND RATES

Name of Hotel		Single	Double	Twin Beds
MEDFORD	Without Bath	$2.25	$3.50 to $ 4.00	$4.50
	With Bath	$3.00 to $ 3.75	$4.25 to $ 5.25	$6.00 to $ 7.00
PFISTER	Without Bath	$3.00 to $ 4.50	$5.50 to $ 7.00	$5.50 to $ 7.00
	With Bath	$3.50 to $ 8.00	$6.50 to $10.00	$7.00 to $12.00
PLANKINTON HOUSE	Without Bath			
	With Bath	$4.00 to $ 6.00	$6.00 to $ 8.00	$7.00 to $10.00
RANDOLPH	Without Bath	$2.25	$3.50	
	With Bath	$3.00 to $ 3.25	$5.00 to $ 5.50	$6.00 to $ 6.50
SCHROEDER	Without Bath			
	With Bath	$3.75 to $10.00	$6.50 to $10.00	$8.00 to $12.00
WISCONSIN	Without Bath	$2.50 to $ 3.00	$3.75 to $ 4.75	
	With Bath	$3.50 to $ 7.50	$5.50 to $ 9.00	$7.50 to $10.00

A New Annual Meeting Feature . . .

DAILY TEACHING DEMONSTRATIONS

Each day of the 1950 Annual Meeting a complete series of special teaching exhibits and demonstrations will be held in and around the exhibit hall as a means of providing more direct teaching and fewer didactic lectures. The following teaching exhibits or clinics will be held between 9:00 and 10:15 a. m. each day:

1. **OB MANIKIN DEMONSTRATIONS**—SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

   Special problems of delivery will be presented by a recognized teacher in the fields of obstetrics and gynecology. By use of a manikin the demonstrator will cover the use of forceps, breech presentation, and various methods of delivery as well as version and extraction. Opportunities will be offered for questions and discussion by those in attendance. Program arranged by Wisconsin Society of Obstetrics and Gynecology.

2. **FRACTURE DEMONSTRATIONS**—EXHIBIT HALL, MILWAUKEE AUDITORIUM

   This demonstration will be conducted by prominent Wisconsin orthopods, and will cover various topics related to the application of casts commonly applied. Details of the demonstrations are now being worked out and will be announced at a later date.

3. **BLOOD TRANSFUSIONS**—EXHIBIT HALL, MILWAUKEE AUDITORIUM

   The staff of Children's Hospital, Milwaukee, is presenting a special exhibit and demonstration on blood transfusions, with special reference to blood replacement in erythroblastosis. Various phases, such as blood matching and technics particularly related to pediatric practice will be featured in this daily demonstration.

4. **PATHOLOGIC CLINIC**—NORTH JUNEAU HALL, MILWAUKEE AUDITORIUM

   Each morning of the 1950 Annual Meeting the Wisconsin Society of Pathologists will conduct a pathologic clinic on a variety of subjects. This special teaching feature of the program will be supplemented by a gross tissue display and demonstration which will be held simultaneously in the exhibit hall.

5. **ANATOMY DISSECTIONS**— EXHIBIT HALL, MILWAUKEE AUDITORIUM

   The Anatomy Department of the University of Wisconsin will conduct a demonstration of the nerves of the viscera and the surgical approaches to parts of the autonomic nervous system. This will consist of a dissection of the nerves in the neck, thorax, abdomen, and pelvis in one specimen. In another subject the demonstration will show the surgical approaches to, and exposure of, certain of the nerves.

6. **X-RAY INTERPRETATIONS**—WALKER HALL, MILWAUKEE AUDITORIUM

   The Wisconsin Radiologic Society will present a daily demonstration to provide those in attendance with a more complete interpretation of x-rays most closely related to general practice. These x-ray clinical conferences will be under the direction of S. A. Morton, M. D., Milwaukee, and L. W. Paul, M. D., Madison. This feature of the program is especially planned for physicians other than those in the specialty of radiology.

7. **ANESTHESIA DEMONSTRATIONS**—EXHIBIT HALL, MILWAUKEE AUDITORIUM

   The scientific exhibit prepared by the Wisconsin Society of Anesthesiologists will feature demonstrations on mechanical factors in control of spinal anesthesia and the physical factors involved in respiratory activity.

8. **THE ARTIFICIAL KIDNEY**—NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

   Arrangements have been made with the staff of Columbia Hospital, Milwaukee, to demonstrate the artificial kidney and explain its function in therapy.

Still More Direct Teaching . . .

MONDAY, OCTOBER 2

To supplement the teaching demonstrations and exhibits described on page 529, the Council on Scientific Work has arranged to have the staffs of Children's Hospital, Milwaukee County Hospital, and Veterans Hospital, Wood, present the following staff conferences simultaneously on MONDAY, OCTOBER 2.

SURGICAL–MEDICAL STAFF CONFERENCE

Staff of Milwaukee County Hospital — Plankinton Hall, Milwaukee Auditorium

Joseph M. King, M. D., Chairman, Surgical Section
Francis Murphy, M. D., Chairman, Medical Section

10:30 a. m.: DIAGNOSIS AND TREATMENT — TUMOR OF URINARY BLADDER: Robert S. Irwin, M. D.

10:42 a. m.: MEDICAL DIAGNOSTIC PROBLEM: Joseph A. Bartos, M. D.

10:54 a. m.: PLANTAR ULCER IN A DIABETIC TREATED BY PLASTIC SURGERY: Volney B. Hyslop, M. D.

11:06 a. m.: FEVER CONVULSION: M. G. Peterman, M. D.

11:18 a. m.: SPONTANEOUS RUPTURE OF THE SPLEEN: E. A. Bachhuber, M. D.

11:26 a. m.: SALT DEPLETION AS A COMPLICATION IN THE TREATMENT OF HEART FAILURE: P. G. La Bissioniere, M. D.

PEDIATRIC STAFF CONFERENCE

Staff of Children's Hospital, Milwaukee — Walker Hall, Milwaukee Auditorium

Frank J. Mellencamp, M. D., Chairman

10:30 a. m.: NEPHRITIS: Ted Buszkiewicz, M. D.

10:45 a. m.: DIABETES: Karl Beck, M. D.

11:00 a. m.: CONVULSIVE DISORDERS: Niels Low, M. D.

11:15 a. m.: COMMON SKIN LESIONS IN CHILDHOOD: Donald M. Ruch, M. D.

11:30 a. m.: HEMATOLOGIC CASES: Daniel Claudon, M. D.

SUPPURATIVE PULMONARY DISEASES

Staff of Veterans Hospital, Wood — Engelmann Hall, Milwaukee Auditorium

Maurice Hardgrove, M. D., Chairman

10:30–11:00 a. m.: MEDICAL ASPECTS OF SUPPURATIVE PULMONARY DISEASES: George C. Owen, M. D., and Donald M. Willson, M. D.

11:00–11:30 a. m.: SURGICAL ASPECTS OF SUPPURATIVE PULMONARY DISEASES: Forrester Raine, M. D., and Wilson Weisel, M. D.

All presentations will feature use of patients.

45 ROUND TABLES— WITH LIMITED PARTICIPATION!

The increasing popularity of the noon round-table luncheons has prompted the Council on Scientific Work to schedule a full program of 15 discussion groups each day. The majority of these are strictly scientific, with a wide choice of topics to be announced by special mailing the latter part of July. If you are planning to be out of the city, instruct your office girl to forward the material to you so that you can send in your reservation as quickly as possible.

In addition to the scientific round tables there will be two special luncheons of interest to many members:

1. COUNTY SECRETARIES LUNCHEON, MONDAY, OCTOBER 2: All secretaries are urged to attend this special luncheon, the cost of which is underwritten by the State Medical Society, at which county officers can meet with A.M.A. officials and state office personnel to discuss various matters of special concern to those physicians concerned with organizational affairs of county groups.

2. M. D. BUSINESS PROCEDURES LUNCHEON, TUESDAY, OCTOBER 3: A special luncheon for those physicians who wish to discuss matters of a medical–legal nature, insurance problems as related to the individual and medical practice, and so forth. Legal counsel of the State Society, an insurance authority, and other selected personnel will be in attendance to assist with the discussion and help answer questions of those participating in this special feature of the 1950 program.

OUTSTANDING TEACHERS ON GENERAL PROGRAM

All details of the scientific program had not been arranged at the time the June issue of the Journal went to press, but a condensed outline of some featured speakers will indicate the variety of the material to be presented:

General Program Highlights

ACUTE NEPHRITIS AND LOWER NEPHRON NEPHROSIS: Francis Murphy, M. D., Milwaukee

MULTIPLE SCLEROSIS: A. B. Baker, M. D., Minneapolis

THE USE OF ANTIBIOTICS IN OTOLARYNGOLOGY: Francis L. Lederer, M. D., Chicago

FLUID THERAPY WITH SPECIAL REFERENCE TO THE ROLE OF POTASSIUM: Daniel Darrow, M. D., New Haven, Conn.

SPECIAL PROBLEMS OF THE ADOLESCENT CHILD: Joseph A. Johnston, M. D., Detroit

EARLY DIAGNOSIS OF UTERINE CANCER AND ITS MANAGEMENT: Michael J. Jordan, M. D., New York City

THE PRESENT STATUS OF THE SURGICAL TREATMENT OF THYROID DISEASE: Richard Cattell, M. D., Boston

RECOGNITION AND TREATMENT OF TUMORS OF THE FACE AND NECK: J. Barrett Brown, M. D., St. Louis

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners following examination on April 19:

Name	*School of Graduation*	*Year*	*Address*
Amberson, H. R.	Illinois	1924	Route 4, West Bend
Anderson, M. G.	Minnesota	1947	515 Delaware Street, S.E., Minneapolis
Balcer, E. A.	Loyola	1938	143 Harvard Avenue, Chicago
Clahassey, E. G.	Michigan	1944	143 North Homan Avenue, Chicago
Herweg, J. C.	Washington	1945	4827 A. Potomac, St. Louis
Holm, A. G.	Northwestern	1938	Veterans Administration Hospital, Wood
Kirmse, T. W.	Chicago	1934	2018 Lewis Street, Marinette
Kordiyak, George	Loyola	1943	6401 West Thirty-Fourth Street, Berwyn, Ill.
Lawrence, P. J.	Vermont	1931	Lake View Sanatorium, Madison
Leiter, F. C.	Indiana	1945	7922 Ingleside Avenue, Chicago
McNamara, T. B.	Loyola	1944	417 Custer Avenue, Evanston, Ill.
Quinlivan, J. K.	Buffalo	1945	1300 University Avenue, Madison
Rhoades, A. L.	Washington	1946	16 South Henry Street, Madison
Rodin, Max	Manitoba	1945	Milwaukee County Hospital, Milwaukee
Thacker, C. W.	Pennsylvania	1947	Richland Center
Welton, P. C.	Marquette	1937	10437 West Watertown Road, Milwaukee

The following physicians, whose names were not previously published, have been granted licenses by reciprocity by the State Board of Medical Examiners:

Nelson, L. F.	Illinois	1947	St. Joseph's Hospital, Marshfield
Otsuka, R. M.	Rush	1937	134 North Washington, Naperville, Ill.
Schmidt, L. E.	Northwestern	1895	316 Ruder Street, Wausau
Swirsky, Albert	Loyola	1941	Milwaukee County Hospital, Milwaukee

The following physicians were licensed by the State Board of Medical Examiners after they had successfully passed an examination at Madison on January 10–12:

Doherty, G. O.	Marquette	1949	1904 East Fourth Street, Marshfield
Ostling, B. C.	Michigan	1948	211 East Second Street, Hastings, Minn.
Sandgren, G. R.	Marquette	1949	Stratford

News Items and Personals

Sturtevant Celebrates Doctor Peehn Day

The village of Sturtevant paid tribute to its physician, *Dr. Frederick G. Peehn*, on May 13, when it declared a legal holiday for Doctor Peehn Day. The celebration marked a half century of service to the community by the 75 year old doctor, who arrived there shortly after his graduation from medical school in 1900. Festivities were held in the village hall, where a noon dinner was served by the Sturtevant Community Club. Following a welcome by Mr. John R. Loizzo, village president, numerous civic and professional leaders told of the doctor's contributions to the village. *Dr. Beatrice O. Jones*, president of the Racine County Medical Society, spoke in behalf of that organization. Two other physicians who have been in the profession for more than fifty years—*Drs. W. C. Hanson* of Racine and *R. W. McCracken* of Union Grove—spoke of their work with the doctor. Many speakers echoed warnings about the threat of government in medicine. Doctor Peehn was given a gold plaque, and Mrs. Peehn was presented with a bouquet of roses. A banquet sponsored by the Sturtevant Lions Club climaxed the celebration.

Doctor Sturtevant, a native of Ives Grove, obtained his medical degree from Marquette University School of Medicine in 1900, locating in Sturtevant that same year. For forty years he has been health officer for the Milwaukee Road.

Marinette Pathologist Addresses Michigan Group

Dr. R. J. Rogers, Oconto pathologist, addressed members of the Marquette Alger Medical Society on April 18 at the Marquette Club in Marquette, Mich. His subject was the "Practical Application of the Cytologic Diagnosis of Malignancy." Doctor Rogers is the pathologist for the Marinette General Hospital, St. Joseph's Hospital in Menominee, Mich., Oconto County and City Hospital, and St. Francis Hospital, Escanaba, Mich. He is also a consultant in pathology for the Veterans Administration Hospital, Iron Mountain, Mich.

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SEARLE

Anti-Tuberculosis Association Reelects Officers

Meeting at the Hotel Schroeder, May 9–11, the Wisconsin Anti-Tuberculosis Association reelected the Rev. Anthony F. Berens, S. J., president of the organization. Other officers reelected were *Dr. Henry A. Anderson*, Stevens Point, vice-president; *Dr. Carl N. Neupert*, Madison, second vice-president; *Dr. Elwood W. Mason*, Milwaukee, secretary; and C. F. Illsley, Milwaukee, treasurer.

Dr. Homer Baker Enters Practice in Wonewoc

Dr. Homer Baker, physician at Brodhead since 1948, this month began practice at Wonewoc. A graduate of the University of Wisconsin Medical School, Doctor Baker served in the United States Navy from 1942 to 1947.

Dr. A. H. Heidner Addresses Rotarians

Members of the West Bend Rotary Club on May 2 heard a discussion on the detection and cure of cancer by *Dr. A. H. Heidner* of that city. A movie on the subject was presented in connection with the address. Doctor Heidner is the Fifth District Councilor of the State Medical Society.

Monroe Physician Moves to Wyoming

Dr. G. Walter Marbry, a member of the staff of the Monroe Clinic, Monroe, since 1946, left on June 1 to take up practice in Cheyenne, Wyoming. Doctor Marbry, a graduate of the University of Wisconsin Medical School, specializes in treatment of the eye, ear, nose, and throat.

Marshfield Dermatologist Addresses Minnesota Physicians

Dr. Stephan Epstein, Marshfield dermatologist, participated in a symposium on allergy at the meeting of the Minnesota State Medical Association, Duluth, Minn., on June 13. The program of the section on allergy was under the auspices of the American College of Allergists, of which Doctor Epstein is a regent.

Racine Physician Certified by Specialist Board

Dr. Louis J. Kurten, Racine physician, on February 16 received notification that he had been certified as a diplomate of the American Board of Internal Medicine, following successful completion of his examinations. A graduate of Northwestern University School of Medicine, Doctor Kurten completed an internship and residency training at the Milwaukee County General Hospital. Following service in the United States Navy during World War II, he became associated in practice with his brother, *Dr. Russell M. Kurten*, at Racine.

Dr. J. A. Junck Celebrates Fiftieth Anniversary of Practice

A family dinner was held on May 14 to celebrate the completion of fifty years of medical practice by *Dr. John A. Junck*, one of Sheboygan's oldest practicing physicians. Doctor Junck, now 78 years old, began his practice in Sheboygan in 1900, following his graduation from the University of Indiana College of Medicine.

Clintonville Physicians Attend Medical Meeting in Michigan

Drs. Robert H. Pfeifer and *Clarence A. Topp*, Clintonville physicians, were among the medical men attending a three day meeting at the Parke, Davis and Company laboratories, in Detroit late in April.

Platteville Physician Returns From Postgraduate Course

Dr. G. W. Bair, Platteville physician, returned to that city on May 1, following a month's postgraduate course in surgery at the Cook County Postgraduate School of Medicine and Hospital, Chicago. Doctor Bair has practiced in Platteville since 1948, following his discharge from the United States Navy.

Three Physicians Address Neenah Hospital Staff

Three Outagamie County physicians spoke at a pathologic conference of the Theda Clark Memorial Hospital staff on May 12. Drs. C. W. Aldridge and *A. C. Taylor* of Appleton and *Dr. E. R. Strauser* of Neenah entitled their presentation "This Time It's Your Problem."

Dr. W. B. Hildebrand Attends Chicago Meeting

Dr. W. B. Hildebrand, Menasha, attended the convention of the American Association of Industrial Physicians and Surgeons at Chicago, April 24–28. Headquarters were at the Hotel Sherman. Doctor Hildebrand is the secretary of the Wisconsin chapter of the American Academy of General Practice.

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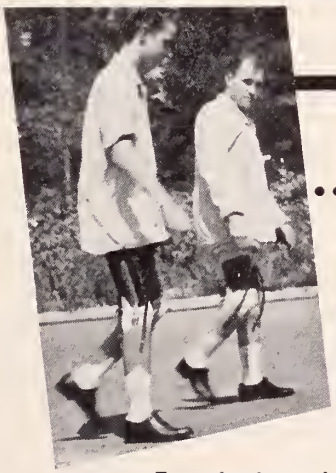

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Society Proceedings

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society adjourned until September following its meeting at the Northland Hotel, Green Bay, on May 11. A demonstration and discussion of portable oxygen equipment was present by Mr. Jack Foster of the Linde Air Products Company. His talk was based on the possibilities of using this type of therapy in the home.

Jefferson

Meeting at the Carlton Hotel in Watertown on May 18, members of the Jefferson County Medical Society heard a discussion of "Blue Cross and Blue Shield for the Doctor and His Family." Guest speakers on the subject were Mr. Edmund Funk of Elm Grove, a representative of Blue Cross–Blue Shield, and Mr. Ralph Weber, director of Wisconsin Physicians Service.

Kenosha

Dr. Edwin C. Albright, assistant professor of internal medicine at the University of Wisconsin Medical School, was the guest speaker at a meeting of the Kenosha County Medical Society held at the Oage Thomsen Restaurant in Kenosha on May 4. Doctor Albright discussed "Atomic Medicine." Two representatives of Blue Cross–Blue Shield were present to discuss the plan.

Outagamie

"Diagnosis and Treatment of Carcinoma of the Rectum and Colon" was the title of a paper presented before the Outagamie County Medical Society at a meeting at the Elks Club in Appleton on March 16 by *Dr. Robert McCarty* of Milwaukee. Discussants were *Drs. Joseph Benton, Arthur Taylor,* and *G. L. Boyd.* At the business session, a city-county health unit was recommended and set up.

Trempealeau—Jackson—Buffalo

Members of the Trempealeau–Jackson–Buffalo County Medical Society gathered at St. Jospeh's Hospital in Arcadia on April 27 to hear a talk by *Dr. Archie A. Skemp* of La Crosse. Doctor Skemp spoke on the status of medicine and the medical profession in this day of specialization and organized minority pressure groups. *Dr. R. L. MacCornack* of Whitehall discussed the presentation.

Walworth

Members of the Walworth County Medical Society entertained their wives at a dinner meeting at the Hotel Burlington in Burlington on April 20. Guest speakers were two Chicago physicians—Drs. Walter J. Reich and Mitchell J. Nechtow—both specialists in obstetrics and gynecology. They discussed modern problems in their field.

Washington—Ozaukee

"Treatment of Nephritis" was the title of a paper presented before a meeting of the Washington–Ozaukee County Medical Society at the Schwartz in Hartford on April 27. *Dr. Bruno Peters,* Milwaukee, assistant clinical professor of medicine at Marquette University School of Medicine, was the guest speaker. Members of the Auxiliary were guests at the dinner preceding the talk by Doctor Peters, and later they held a separate meeting.

Winnebago

H. J. LEE

Members of the Winnebago County Medical Society met at the Hotel Athearn, Oshkosh, on May 4, to hear a talk by *Dr. Howard J. Lee,* assistant clinical professor of medicine at Marquette University School of Medicine, Doctor Lee discussed "Problems in the Treatment of Bronchial Asthma."

Wisconsin Society of Pathologists

The spring meeting of the Wisconsin Society of Pathologists was held at the Marquette University School of Medicine on May 20. Following the scientific session, a social hour, dinner, and business meeting were held at the Milwaukee Athletic Club in the evening. Participating in the day's program were the following physicians: *Drs. Gorton Ritchie,* Milwaukee, who discussed "Two Cases of Suppurative Pericarditis"; *Raymond J. Rogers,* Oconto, presenting "Practical Applications of Exfoliative Cytology in the Diagnosis of Malignancy"; *Dr. John B. Miale,* Marshfield, speaking on "The Role of Staphylocoagulase in Blood Coagulation—The Relationship to Prothrombin Activity"; Dr. Frank T. Hamilton, Wood, discussing "Peliosis Hepatis"; *Dr. Joseph M. Lubitz,* Wood, presenting "A Survey of Amebiasis"; *Dr. Edward A. Birge,* Milwaukee, speaking on "Atypical Acid-Fast Infection"; and *Dr. L. J. Kreissl,* Milwaukee, describing the "Three Stage Management of Hemolytic Transfusion Reaction."

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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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Wisconsin Urological Society

Dr. A. Dwight Spooner, Milwaukee, was named president of the Wisconsin Urological Society at its annual meeting held on May 6 at the Wausau Club in Wausau. He succeeds *Dr. Robert Irwin* of Milwaukee. Officers who will serve with Doctor Spooner are *Dr. H. W. Christensen*, Wausau, vice-president; and *Dr. Sidney Silbar*, Milwaukee, secretary-treasurer.

Guest speaker at the evening meeting was Dr. John Emmett, a member of the staff of the Mayo Clinic, whose topic was "Urogenital Tuberculosis." His talk followed a testimonial dinner in honor of Dr. Louis Schmidt, formerly of Chicago and now a resident of Wausau.

The following papers were presented during the morning sessions: "Ruptured Urethra in a Child," by *Dr. John J. Mueller*, La Crosse; "Imperforate Anus," *Dr. Emerson Collier*, Madison; "Ureterocele," *Dr. Sidney Hurwitz*, Milwaukee; "Schistomiasis Haematobium," *Dr. E. F. Cummings*, Oshkosh; "An Improvement in Instrument Lighting," *Dr. Albert Graham*, Neenah; and "Carcinoma of the Kidney with Renal Tuberculosis," *Dr. Joseph Skibba*, Appleton.

During the afternoon the following subjects were discussed: "Genitourinary Injury," *Dr. Leland Pomainville*, Wisconsin Rapids; "Sarcoma of the Bladder," *Drs. I. E. Kolman* and *I. R. Sisk*, both of Madison; "Extrophy of the Bladder," *Dr. John Hotter*, Milwaukee; "Wilms Tumor," *Dr. Norman Helland*, Madison; and "Stone Dissolution," Dr. Timothy McDonnell, Milwaukee. A pyelogram clinic was also presented by *Drs. Sidney Silbar* and *N. Warren Bourne* of Milwaukee and *Alfred Gundersen*, La Crosse, with *Dr. H. M. Stang*, Eau Claire, as moderator.

Wisconsin Society of Obstetrics and Gynecology

Dr. J. W. Prentice, Ashland, was named president of the Wisconsin Society of Obstetrics and Gynecology at the annual spring meeting of the organization, held at the University Club, Milwaukee, on May 5. *Dr. L. V. Sprague*, Madison, was elected vice-president, and *Dr. Alice D. Watts*, Milwaukee, secretary-treasurer.

Guest speaker for the occasion was Dr. Rockwell Levine, head of department of endocrinologic research at Michael Reese Hospital, Chicago. The following papers were presented at the scientific session, which was held during the morning: "Management of Bleeding in Eary Pregnancy," by *Dr. M. A. Krembs*, Milwaukee; "Indications for Hysterectomy in a Community of 50,000," by *Dr. J. F. Egan*, La Crosse; "Nisentil—A New Analgesic Drug for Use in Obstetrics," by *Dr. Christine Thelen*, Madison; "Delayed Gastric Emptying Time in Labor," by *Dr. E. A. Steffen*, Racine, with discussion by *Dr. Wilson Phillips*, chairman of the department of anesthesia, Mount Sinai Hospital, Milwaukee; "Forum on Prolonged Labor," by *Dr. R. E. McDonald*, Milwaukee; "The Problem of Obesity in Gynecology," by *Dr. F. J. Stoddard*, Milwaukee; and "Pregnancy and Diabetes," by Doctor Levine of Chicago.

Wisconsin Surgical Society

Eighty members from throughout the state attended the annual meeting of the Wisconsin Surgical Society, held at the State of Wisconsin General Hospital, Madison, on April 29. *Dr. Warner S. Bump*, Rhinelander, was installed as president, and *Dr. Arnold S. Jackson*, Madison was named president-elect. *Dr. Frank Weeks* of Ashland was reelected secretary-treasurer.

The Madison program, presented by Madison physicians, was as follows: "Cystic Disease of the Lung," by *Dr. William P. Young;* "The Surgical Treatment of Pulmonary Abscess," by *Dr. John T. Mendenhall;* "Mediastinal Tumors," by *Dr. Anthony R. Curreri;* and "Carcinoma of the Lung," by *Dr. Joseph W. Gale*. Following a noon luncheon at Wisconsin General Hospital, the following papers were presented: "Repair of Extensor Injuries of the Forearm," by *Dr. Frederick Bunkfeldt, Jr.*, Milwaukee; "Colles' Fracture," by *Nathan E. Bear*, Monroe; "Renewed Hope of the Cure of Carcinoma of the Cervix," by *Dr. Paul F. Doege*, Marshfield; Vaginal Hysterectomy," by *Drs. Rogert T. Cooksey* and *Samuel B. Harper*, Madison; and "Gallbladder Surgery: A Study of the Results of Surgical Treatment in Rock County, Wisconsin," by *Drs. Thomas J. Snodgrass*, Janesville; *W. A. Munn*, also of Janesville; and *Thomas H. Flarity*, Beloit.

Wisconsin Section, International College of Surgeons

The Wisconsin Section of the International College of Surgeons met at the Jackson Clinic, Madison, on May 20 for a scientific meeting. Luncheon was served to the group at the Hotel Loraine. The following program was presented: "Present Status of the Treatment of Hyperthyroidism," by *Dr. Arnold S. Jackson*, Madison; "Sympathectomy in the Treatment of Hypertension," by *Dr. George H. Ewell*, Madison; "Preoperative and Postoperative Care of Gastric Resection Cases," by *Dr. George P. Schwei*, Madison; "Carcinoma of the Cervix," by *Dr. Paul Doege*, Marshfield; "Intestinal Obstruction," by *Dr. Dexter Witte*, Milwaukee; and "Brunner's Gland Tumor," by *Dr. William Clark*, Oshkosh.

Wisconsin Radiological Society

The Wisconsin Radiological Society held its first annual meeting on May 20 at the Edgewater Hotel, Madison. At the business meeting, which followed the scientific session, *Dr. E. A. Pohle*, professor of radiology at the University of Wisconsin Medical School, was installed as president. Both he and the secretary-treasurer of the organization, *Dr. I. I. Cowan* of Milwaukee, were reelected for another term of one year. Other officers chosen include *Dr. L. V. Littig*, member of the board of censors, and *Dr. H. H. Wright*, Milwaukee, member of the board of directors.

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"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Madison Doctor Heads Red Cross Committee

Dr. Etheldred Schafer, Madison physician, was elected chairman of the regional medical advisory committee for the Red Cross blood program in southern Wisconsin at a meeting on May 11 at the Heidelberg Hofbrau, Madison. *Dr. Walter Jaeschke*, a member of the medical advisory committee of the Dane County chapter of the Red Cross, was elected secretary.

Dr. James MacGregor Speaks at Wisconsin Dells

Members of the Civic Club of Wisconsin Dells on April 26 heard a talk by *Dr. James MacGregor*, Portage, on "How to Be Better Parents." The doctor offered suggestions for the care of pre-school age children and for the understanding of adolescent boys and girls. A film from the State Board of Health supplemented his talk.

Madison Physician Addresses Parent Group

Members of the Auxiliary to the La Crosse County Medical Society and of the Parent–Teacher Association of the training school at La Crosse heard *Dr. H. Kent Tenney*, Madison pediatrician, talk at the training school on April 25. Doctor Tenney, who is also an associate professor of pediatrics at the University of Wisconsin Medical School, discussed the "Emotional Problems of Young Children."

On May 17 he spoke on the same subject at the second annual dinner of the Dane County Child Guidance Center, a Community Chest agency, in Madison.

SOCIETY PROCEEDING

Dane County Chapter, American Academy of General Practice

Dr. R. H. Ludden, Madison, was named president of the Dane County Chapter of the Academy of General Practice at its organizational meeting on May 11 at the Park Hotel, Madison. *Dr. R. F. Collins* was elected secretary. The charter was presented to the chapter by *Dr. George Forkin*, Menasha, president of the Wisconsin chapter of the group. *Dr. William Hildebrand*, secretary of the state chapter, and *Dr. O. F. Foseid*, both of Menasha, were the guest speakers.

TWELFTH DISTRICT NEWS

Clinical Day Held at Veterans Administration Hospital, Wood

A clinical day, sponsored by the Veterans Administration Hospital and the dean's committee of Marquette University School of Medicine, was conducted by residents of the Veterans Administration Hospital at Wood on June 15. The Committee on Publicity and Entertainment for the event consisted of *Drs. Jack J. Levin*, Robert A. O'Connell, *and A. J. Krygier.*

Dr. Robert L. Paver, senior resident in the medical service was chairman of the morning session. Following opening remarks by Dr. Roderick G. St. Pierre, chief medical officer; *Dr. John S. Hirschboeck*, dean of Marquette University School of Medicine; *Dr. Carl W. Eberbach*, surgical member of the dean's committee; and *Dr. Fred W. Madison*, medical member of the dean's committee, the following papers were presented: "Effect of Stellate Ganglion Block on Retinovasospasm," by *Dr. Arvid G. Holm*, president in ophthalmology; "Unusual Aneurysm of the Aorta," by Dr. Walter A. Huttner, resident in internal medicine; "Experimentally Induced Hypoprothrombinemia in Dogs," by *Dr. George E. Collentine*, resident in surgery; "Ankylosing Spondylitis, a Disease Entity," by Dr. Robert A. O'Connell, resident in internal medicine; "Surgical Management of Low Back Pain," by Dr. Robert W. Weber, resident in orthopedics; "Benzoyl Glucuronate Excretion as a Test of Liver Function," by *Dr. Max V. Grabiec*, resident in internal medicine (read by *Dr. J. J. Levin*); and "Internal Biliary Fistula Complicating Gastric Resection," by Dr. Louis Hamman, resident in surgery.

Following a luncheon, an afternoon session was conducted by *Dr. Raymond J. Stark*, senior resident of the surgical service. The following subjects were discussed: "Study of Blood Glutathione in Normal and Diabetic Individuals," by *Dr. Eugene F. Brandt*, resident in internal medicine; "Studies of Pancreatic Enzymes during and Following X-Ray Ir-

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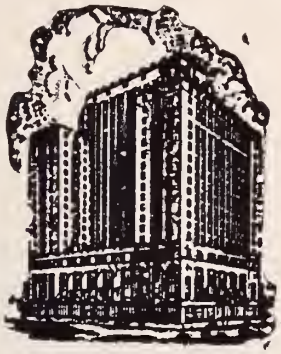

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radiation to the Pancreas," by *Dr. Donald L. Knutson,* resident in radiology; "Esophageal Electrocardiography," by *Dr. Richard Minton,* resident in internal medicine; "Bronchospirometry in the Lateral Decubitus Position," by Dr. Benjamin G. Narodick, resident in surgery; "Zinc Sulphate Turbidity Reaction of Human Serum," by *Dr. David W. Kersting,* resident in internal medicine; and "Aids in Emergency Care of the Comatose Patients," by Dr. Norman J. Barnstein, resident in anethesia.

A dinner dance was held in the evening at the Elks Club, Milwaukee.

Dr. Margaret Hatfield Promoted in Milwaukee Health Department

Dr. Margaret E. Hatfield, former head of the Rock County Health Unit, was recently appointed deputy commissioner of the Milwaukee Health Department, the first woman to hold a high administrative office in that organization. She succeeds *Dr. Anton J. Schramel,* who recently became a district officer for the State Board of Health. Doctor Hatfield, a graduate of the University of Wisconsin Medical School, has recently served as a public health physician in the Milwaukee health department. Several months ago she was certified by the American Board of Preventive Medicine and Public Health.

Marquette Students Entertained by Eli Lilly and Company

Students at Marquette University School of Medicine were guests of Eli Lilly and Company, Indianapolis, on May 7–9. During their visit they made a thorough inspection of the laboratories, including the research laboratories replica of the original laboratories, and the biological laboratories at Greenfield, Ind., where demonstrations were made showing the production of biological products. The Lilly Company sponsored entertainment for the group during the visit, including a tour of Indianapolis and dinners each evening.

Dr. S. H. Kash Reappointed Health Commissioner

Dr. S. H. Kash, Cudahy physician, was reappointed city health commissioner at a special meeting of the board of health on April 27. The doctor has held this position since 1938.

Dr. J. R. Hurley Joins Sanitarium Staff

Dr. James R. Hurley, former director of the Milwaukee County Clinic on Alcoholism, recently assumed the medical and psychiatric direction of the Ivanhoe Sanitarium, Milwaukee, an institution for the treatment of alcoholic patients. A graduate of Tufts College Medical School, Boston, and a diplomate of the American Board of Psychiatry and Neurology, Doctor Hurley served as neuropsychiatric director of the Federal Medical Center, Springfield, Missouri, for three years and was on the staff of the Federal Narcotic Hospital at Lexington, Kentucky for a year. From 1947 to 1948 he was a neuropsychiatric consultant at the Veterans Hospital, Wood.

Milwaukee Physicians Address Medical Technologists

Among the physicians who addressed the Wisconsin Association of Medical Technologists at its spring convention April 29–30, were *Drs. Mabel Tuchscherer* and *Anthony V. Pisciotta* of the Milwaukee County Hospitals; Dr. Marie Koch of the Veterans Administration Hospital, Wood; and *Drs. M. C. F. Lindert, Silas M. Evans,* and *John S.*

Students from Marquette University School of Medicine pose in front of the Lilly Research Laboratories, Indianapolis, during their visit May 7 to 9.

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Hirschboeck of Marquette University School of Medicine. Dr. Frank Hamilton, of the Veterans Administration Hospital staff, spoke at a dinner on Saturday evening.

Dr. M. J. Lustok Speaks to Legionnaires

Members of the American Legion at Lake Geneva were advised to ease up after reaching the age of 40 in a talk by *Dr. Mischa J. Lustok,* Milwaukee, at a meeting in Lake Geneva on April 20. Doctor Lustok, a lecturer for the Wisconsin Heart Association, showed a movie entitled "Be Your Age" in connection with his talk.

Dr. Marian Lewis Awarded Scholarship

Dr. Marian Lewis, physician in the turberculosis control center of the Milwaukee health department, was awarded a scholarship by the Wisconsin Anti-Tuberculosis Association for a course in tuberculosis at Saranac Lake, New York, during the month of May. The course was conducted by the Trudeau School of Tuberculosis.

Scholarships are given each year by the state anti-tuberculosis association to graduates of approved medical schools. Preference is given to those with experience in the field of tuberculosis or those who plan to specialize in internal medicine.

SOCIETY PROCEEDINGS

Milwaukee

Dr. Andrew C. Ivy, vice-president of the University of Illinois in charge of professional colleges, was the guest speaker at a meeting of the Medical Society of Milwaukee County on May 12 at the Milwaukee Athletic Club. Doctor Ivy spoke on research being done in various fields of medicine.

Prize winners were also announced in the Anthony J. Gramling Memorial Essay Contest, named for the first Milwaukee doctor to die in World War II. *Dr. Howard L. Correll* was awarded first prize for his paper entitled "Vagovagal Syncope Due to Digitalization." Second prize went to *Drs. M. C. F. Lindert,* M. F. Koszalka, *Harry B. Lerner,* and *H. M. Snodgrass* for their paper on hepatitis. *Dr. Julius Meyer* was given honorable mention for his paper, "Red Cell Mass."

Milwaukee Academy of Medicine

Members of the University Club of Milwaukee heard a talk by Dr. Samuel M. Feinberg, associate professor of medicine and chief of the department of allergy at Northwestern University Medical School, at the University Club of Milwaukee on May 16. Doctor Feinberg discussed "Antihistamine Therapy; Relation to Allergic and Nonallergic Syndromes." The following morning he conducted a special clinic at the auditorium of Milwaukee County General Hospital.

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society held its annual business meeting at the University Club of Milwaukee on May 17. Guest speaker was Professor Russell E. Oakes.

Milwaukee Oto-Ophthalmic Society

The annual election of the Milwaukee Oto-Ophthalmic Society was held on May 22 at the Wisconsin Club, Milwaukee. Newly elected president is *Dr. J. P. Wild,* and serving with him will be *Dr. B. P. Churchill,* vice-president; *Dr. Howard High,* secretary-treasurer; and *Drs. George Dunker, Samuel Blankstein,* and *F. G. Treskow,* directors. British surgeon Dr. Geoffrey A. Myers was the guest speaker, discussing "The Future of Private Practice."

SOCIETY RECORDS

New Members

R. L. Demke, Elroy.

J. H. Bultema, Waterford.

T. A. Gross, 1300 University Avenue, Madison.

G. M. Schlenker, 1300 University Avenue, Madison.

H. N. Lubing, Winnebago State Hospital, Winnebago.

S. A. Koff, 342 North Water Street, Milwaukee .

A. A. Bullock, Jr., 2200 West Kilbourn Avenue, Milwaukee.

J. L. Teresi, 4408 West Wright Street, Milwaukee.

J. J. Haugh, 2520 North Frederick Avenue, Milwaukee.

Howard Mauthe, 1013 North 23rd Street, Milwaukee.

E. V. Hastings, Milwaukee County Hospital, Wauwatosa.

R. C. Mathewson, 1171 Boylston Street #26, Boston, Massachusetts.

Changes of Address

B. F. Palmer from Three Lakes to 3434 North 55th Street, Milwaukee.

J. A. Stemper from New York to 2316 Edgewood, Milwaukee.

R. J. Rogers, Rochester, Minnesota, to 543 Main Street, Oconto.

A. M. Kurzon, Milwaukee, to 2658 North Racine Street, Chicago, Illinois.

H. R. Duffey, Bremerton, Washington, to Milwaukee County Hospital, Milwaukee.

G. J. Rich, Milwaukee, to 1912 Memorial Avenue, S.W., Roanoke 12, Virginia.

J. L. Ford, Appleton, to 1825 East Palm Lane, Phoenix, Arizona.

G. R. Clarke, Milwaukee, to 1714 Central Union Building, Wheeling, West Virginia.

K. P. Grubb, Jr., Milwaukee, to Veterans Administration, Wood.

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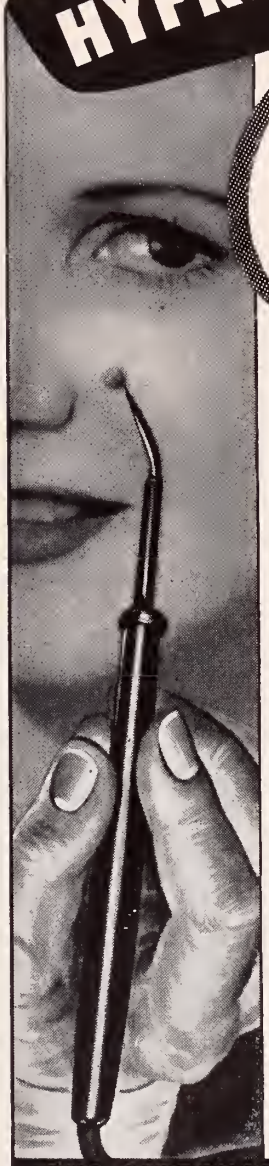

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D. F. Jarvis, Rhinelander, to Koth Building, Tomahawk.

MARRIAGES

Dr. Christine Thelen to Mr. H. Wills Kilbourne, Madison, on May 25.

Dr. Roland Leibenow and Miss Martha Anderson, Stevens Point, on May 5.

Dr. Henry A. Peters and Miss Jean McWilliams, Madison, on May 20.

BIRTH

A daughter to Dr. and Mrs. William A. Tanner, Madison, on April 11.

DEATHS

Dr. George N. Lemmer, retired Spooner physician, died at a hospital in Madison on April 26. He was 77 years old.

Born in Marathon County on July 11, 1872, Doctor Lemmer received his degree in medicine from the Milwaukee Medical College, now Marquette University School of Medicine, in 1901. Following internship at Trinity Hospital, Milwaukee, he established his practice in Spooner, where he continued until his retirement in 1949. For several years he served as city health officer, and during World War I he was commissioned a captain in the Army Medical Corps.

A life member of the State Medical Society, Doctor Lemmer was a founder of the Barron–Washburn–Sawyer–Burnett County Medical Society and was a fellow in the American Medical Association.

Survivors include two daughters and three sons, one of whom is Dr. Kenneth E. Lemmer of Madison.

Dr. Sidney M. Smith, physician in Milwaukee for half a century, died at his home in that city on May 10. He was 76 years old.

A native of Morton, Ontario, Canada, Doctor Smith obtained his medical degree from Queen's University Faculty of Medicine, Kingston, Ontario, in 1900. He established his first practice in South Milwaukee, where he built the South Milwaukee hospital in 1904. In 1912 he opened a practice in Milwaukee.

In 1908 the doctor was elected mayor of South Milwaukee, and during his two year term he made an extensive study of typhoid fever and other diseases. It is believed that this study was an important influence in the construction of the South Milwaukee filtration plant.

Doctor Smith was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

A daughter survives.

Dr. L. N. Schnetz, physician at Racine for forty-five years, died at a Racine hospital on April 30. He was 74 years old.

A lifelong resident of Racine, he was born in that city on June 1, 1875. He received his degree in medicine from the Milwaukee Medical College in 1905, and shortly afterward began practice in Racine. During World War I he served as commanding officer of Ambulance Company 127 overseas.

The doctor was a member of the Racine County Medical Society, the State Medical Society, and the American Medical Association.

There are no immediate survivors.

Dr. Sarah Garrett–Bangsberg, former dean of women and school physician at La Crosse State Teachers College, died at a West Salem hospital on April 1. She was 74 years old.

Doctor Bangsberg was born in Chester County, Pennsylvania, on June 23, 1875. She attended Women's Medical College, Philadelphia, obtaining her degree in medicine in 1911. Following several years in general practice, she came to Wisconsin about thirty-three years ago to work with the state department as an examining physician for Wisconsin normal schools. In 1918 she joined the staff of the La Crosse State Teachers College as school physician and until 1941 she also served as dean of women. She retired from her position on the faculty in 1944.

Doctor Bangsberg is survived by three sons.

Dr. Thomas E. Malloy, physician at Random Lake for more than fifty years, died at a hospital in Sheboygan on May 9, following a long illness. He was 86 years old.

Doctor Malloy was born at Hartford on Nov. 8, 1863. He received his degree in medicine from Northwestern University Medical School in 1894, immediately afterward establishing his practice in Random Lake. He served for a time as village health officer and for many years was chairman of the board of education in that community. In 1939 the citizens honored him on the observance of his forty-fifth years of practice in Random Lake, and in 1944 the Sheboygan County Medical Society paid tribute to him at a dinner in honor of his fiftieth anniversary of practice.

A member of the Fifty Year Club of the State Medical Society, the doctor also held membership in the Sheboygan County Medical Society and the American Medical Association.

A sister survives.

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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting July 10, August 7, September 11.
Personal Course in General Surgery, Two Weeks, starting September 25.
Surgery of Colon & Rectum, One Week, starting September 11.
Esophageal Surgery, One Week, starting October 16.
Breast & Thyroid Surgery, One Week, starting June 26, October 2.
Thoracic Surgery, One Week, starting June 12, October 9.
Gallbladder Surgery, Ten Hours, starting June 19, October 23.
Fractures & Traumatic Surgery, Two Weeks starting June 12, October 9.
Basic Principles in General Surgery, Two Weeks starting September 11.
GYNECOLOGY—Intensive Course, Two Weeks, starting June 19, September 25.
Vaginal Approach to Pelvic Surgery, One Week, starting September 18.
OBSTETRICS—Intensive Course, Two Weeks, starting September 11.
MEDICINE—Intensive General Course, Two Weeks, starting October 2.
Electrocardiography & Heart Disease, Two Weeks, starting July 17.
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THE JOURNAL BOOKSHELF

Clinical Ausculation of the Heart. By Samuel A. Levine, M. D., Clinical Professor of Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital; and W. Proctor Harvey, M. D., Research Fellow in Medicine, Harvard Medical School Assistant in Medicine, Peter Bent Brigham Hospital. Pp. 327, with 286 figures. Philadelphia and London, W. B. Saunders Company, 1949. Price $6.50.

The challenging and intriguing evaluation of heart sounds is extremely well presented in this excellent book. It is simply written and easily read. Heart sounds of every variety are described, classified, and discussed as to mechanism and interpretation. The pitfalls of ausculation and the significance of intelligent listening and evaluation are properly stressed. While emphasizing the key importance of the stethoscope, the authors' ausculatory description is well correlated with phonocardiographic and electrocardiographic patterns. The illustrations are clear, ample, and placed close to the descriptive text for easy perusal. The index is carefully and adequately prepared. Because of its clarity, explanative value, and ease of comprehension, this book is valuable reading for everyone—student and practitioner. H. H. S.

Care of the Surgical Patient; Including Pathologic Physiology and Principles of Diagnosis and Treatment. By Jacob Fine, M.D., Surgeon-in-Chief, Beth Israel Hospital; Professor of Surgery at Beth Israel Hospital, Harvard Medical School. Pp. 544, with 40 figures. Philadelphia and London, W. B. Saunders Company, 1949. Price $8.00.

This book is not a textbook of surgery, but a guide to the basic principles of diagnosis and treatment of surgical diseases and the associated nonsurgical disorders. It represents the opinions and practices of a group of over twenty collaborators at one teaching hospital, under the editorship of Dr. Jacob Fine. Surgical technic is not discussed in detail, but pathologic physiology is stressed. Few references are given, but the opinions expressed are substantiated in the literature or supported by their clinical experience. Part I includes a discussion of the unconscious patient, technics for regional examinations, fluid and electrolyte balance, and nutrition in surgical patients. Next comes a consideration of hemorrhage, traumatic shock, and surgical infections.

Part II, regional and special surgery, takes up burns, neurosurgical disorders, the breast, thoracic

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This book is authoritative, very readable and well indexed and should be a valuable reference work for surgeon, resident, intern, and medical student. —J.T.M.

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Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Ophthalmologist-otolaryngologist wishes to sell forty year old established practice located in an industrial area of Milwaukee. Doctor agrees to work with buyer until business is secure. Address replies to No. 283 in care of the Journal.

FOR SALE: General electric portable shockproof x-ray unit in excellent condition at ⅓ of list price. One new mobile 30 MA, 96 PKV, Fischer shockproof x-ray unit at $795. One new Fischer short wave with hinged drum electrode and arm, FCC type approved, $355. One used Jones metabolism unit guaranteed accurate at one-half price. One new style Hyfrecator used only a few months, at marked reduction. One used direct writing electrocardiograph at about one-half price, factory reconditioned. C. C. Remington, 720 North Jefferson Street, Milwaukee 2. Telephones Daly 8-6368 and Woodruff 2-4028.

FOR SALE: Practice in Central Wisconsin city of 30,000, with equipment, including Hamilton Nu-Tone examining table, Pelton autoclave, x-ray with buckey, Birtcher cautery, diathermy, other essential instruments, and Duran office furniture. Ideal for young man who wishes to begin profitable independent practice. Availiable September 1. Reason for selling: specializing. Address replies to No. 305 in care of the Journal.

WANTED: Qualified public health nurse as county nurse in beautiful southwestern Wisconsin. Generalized service in rural area. Beginning salary, $3,000, plus mileage; vacation and sick leave with pay. Must have own car. Write County Health Department, Court House, Richland Center, Wisconsin.

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WANTED: Locum tenens for the month of August, living quarters and office furnished. Address replies to No. 304 in care of the Journal.

EENT ASSOCIATE WANTED: by Board internist and general surgeon. Small clinic, southern Wisconsin, well located in good industrial, farm, and resort area. Salary guarantee plus percentage, leading to partnership. Address replies to No. 307 in care of the Journal.

AVAILABLE: Surgeon, age 32, married, desires assistantship or association with general surgeon certified by or acceptable to the Board for further training. Completing 3 year approved surgical residency and one year basic sciences in June. Licensed in Wisconsin. Address replies to No. 308 in care of the Journal.

FOR SALE: General practice. Owner retiring after 39 years in the same location in northeast Wisconsin community of 3,500. Home, office, and equipment for sale. Good location, good schools and churches. Can easily be made a partnership. Address replies to No. 290 in care of the Journal.

WANTED: EENT man or ophthalmologist capable of doing refractions for association in clinic in busy Wisconsin area. Address replies to No. 300 in care of the Journal.

WANTED: A position with a group or clinic by a Board-eligible surgeon, age 31, available in August 1950. Address repiles to No. 301 in care of the Journal.

FOR SALE: Country practice in northwest Wisconsin. No competition. Modern residence, ideally located. Annual dairy income in territory. Nothing to buy but five bed room residence, with office room, waiting room, and laboratory in residence. Separate parking and sidewalk to waiting room. Spacious lawn, foliage, and ideal residence. Young man can use extra rooms for hospital rooms. Selling reason: coronary thrombosis. Address replies to No. 170 in care of the Journal.

FOR SALE: Instruments used in general practice, including office scales, electric sterilizer, Baumonometer, and stethoscope, all in excellent condition. Address replies to No. 309 in care of the Journal.

WANTED by well established older F.A.C.S.: A general practitioner for assistant. Married man preferred. Good hospital facilities; salary first six months, then percentage. Apartment available. Suburban area of Twin Cities. Great opportunity for future. Minnesota license or National Boards required. Address replies to No. 303 in care of the Journal.

FOR SALE: Practice and equipment of deceased physician in community of 1,000. Office for rent. Hospital facilities within 15 miles. Address replies to No. 310 in care of the Journal.

FOR RENT: Office of the late Dr. Charles R. Treat, Sharon, Wisconsin. Office fully furnished. Instruments for sale. Call or write to Mrs. Charles R. Treat, Sharon, Wisconsin.

ASSOCIATE WANTED: For general practice in northwest Wisconsin city of 2,500. Dairy farming community 90 miles from Twin Cities. Age up to 35. Especially interested in someone with one or two years' general practice experience or just finishing internship. Address replies to No. 311 in care of the Journal.

AVAILABLE: Columbia Hospital, Milwaukee, has available a one year residency in obstetrics and gynecology same to start on July 1, 1950. Applications are being received now. Contact Mr. J. G. Nordby, Administrator, Columbia Hospital, Milwaukee.

WANTED: Assistant to eventually be associate, either E.E.N.T. or E.N.T. State age, experience (need not be full fledged specialist) and stipend expected. Address replies to No. 312 in care of the Journal.

AVAILABLE: Physician with 2½ years of training in internal medicine would like to assist or become associated with internist from July to October 1950. Address replies to No. 313 in care of the Journal.

FOR SALE: New AO Projectochart and screen with all slides and AO Lensometer. $500 value, will be sold immediately for $400. Address replies to No. 314 in care of the Journal.

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PHYSICIAN WANTED: Physician associate with two other doctors in Twin City area of Wisconsin. General practitioner or preferably man with additional obstetric training. Excellent hospital facilities. Address replies to No. 316 in care of the Journal.

WANTED: Young physician to locate in village of 500 in immediate future. 1 year free rental for living quarters. Can also finance purchase of expensive equipment if this is desirable. This territory has 1,000 people who are not now serviced by any other doctor within the locality. It is located 6 miles from first class hospital and is within 35 miles of Milwaukee. Address replies to No. 317 in care of the Journal.

AVAILABLE: Experienced general practitioner desires association or independent practice in medium-sized city with hospital facilities. Address replies to No. 315 in care of the Journal.

AVAILABLE: Locum tenens for recent graduate. General practice. Two man clinic, 100 per cent up-to-date set-up in small town. Affords excellent introduction to general practice. Address replies to No. 318 in care of the Journal.

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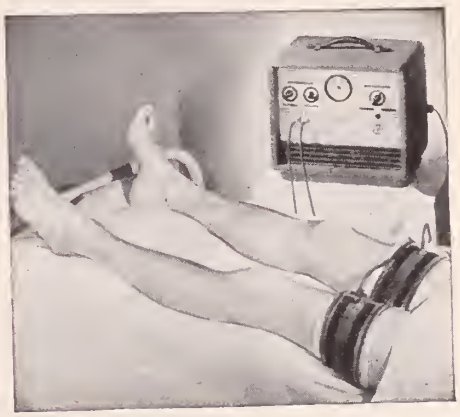

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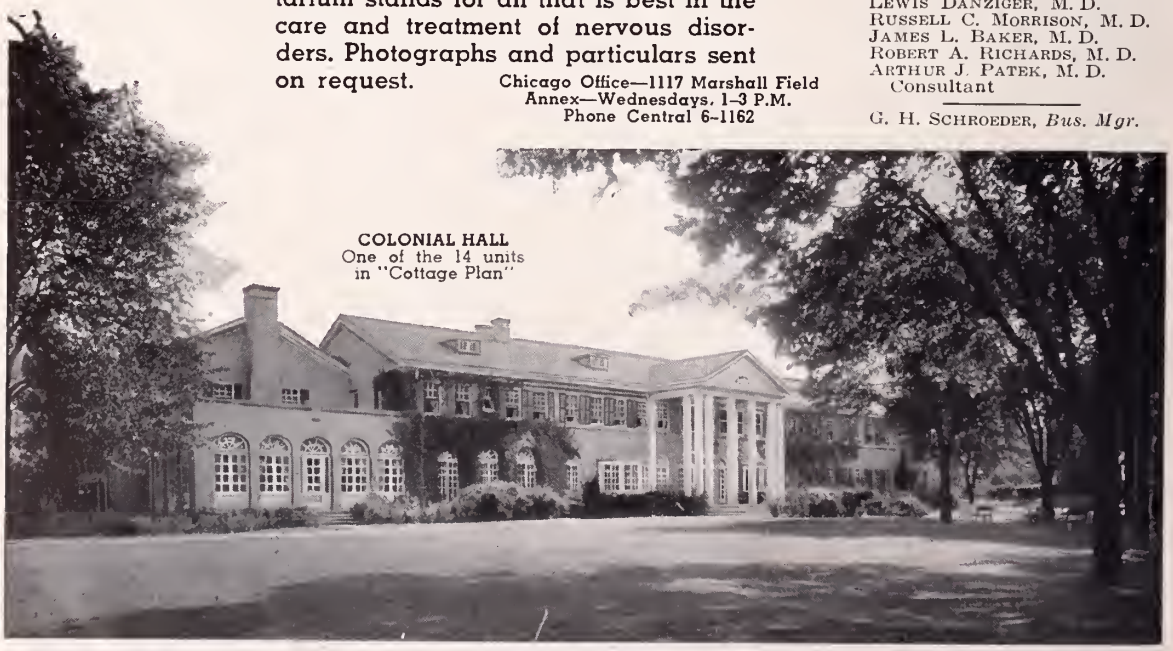

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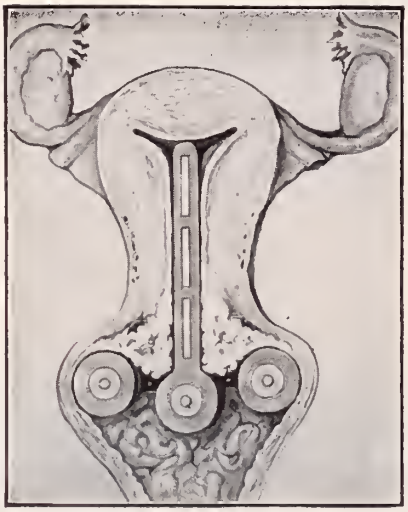

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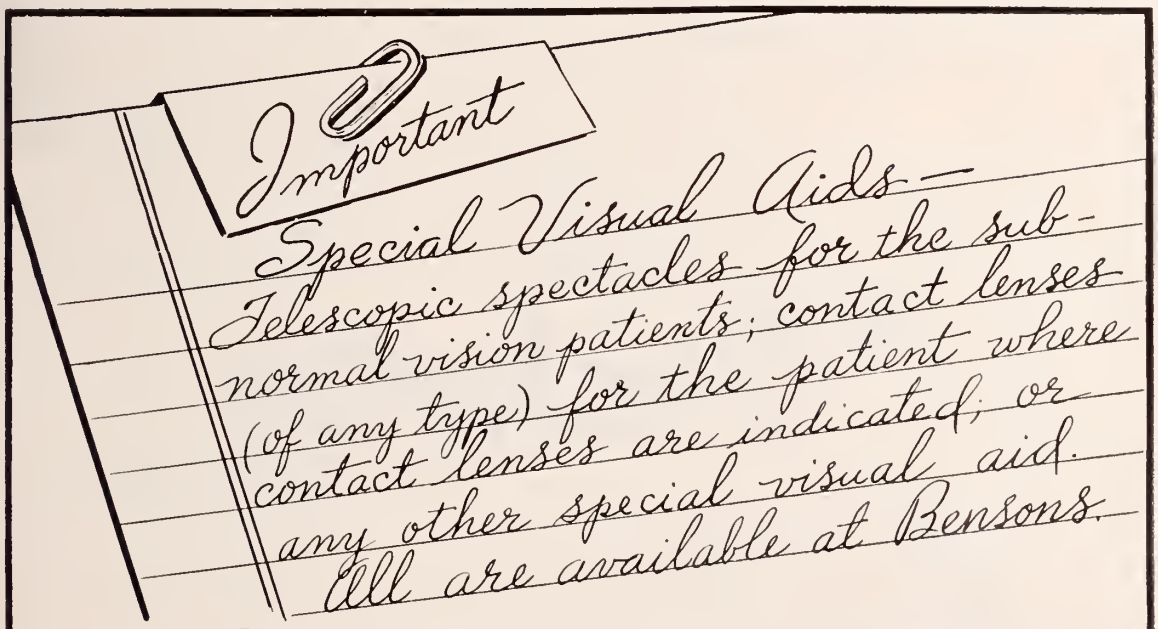

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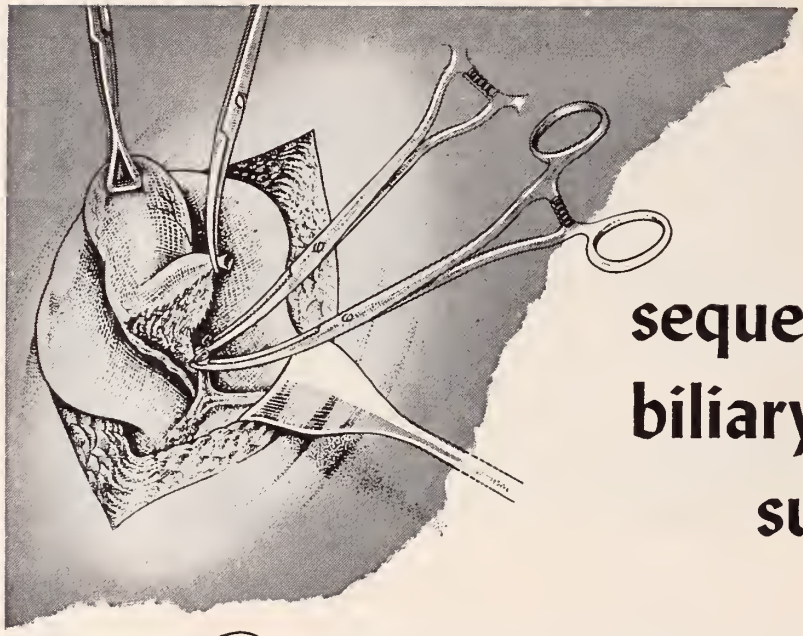

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1. Best, R. R.: Ann. Surg. *128*: 348 (Sept.) 1948.

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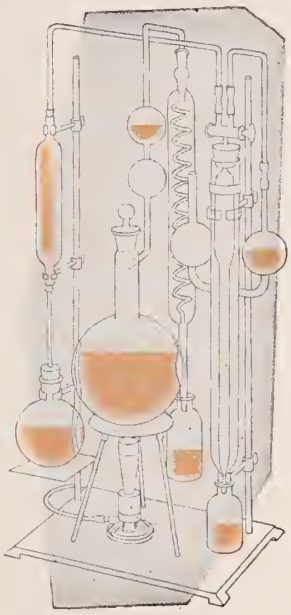

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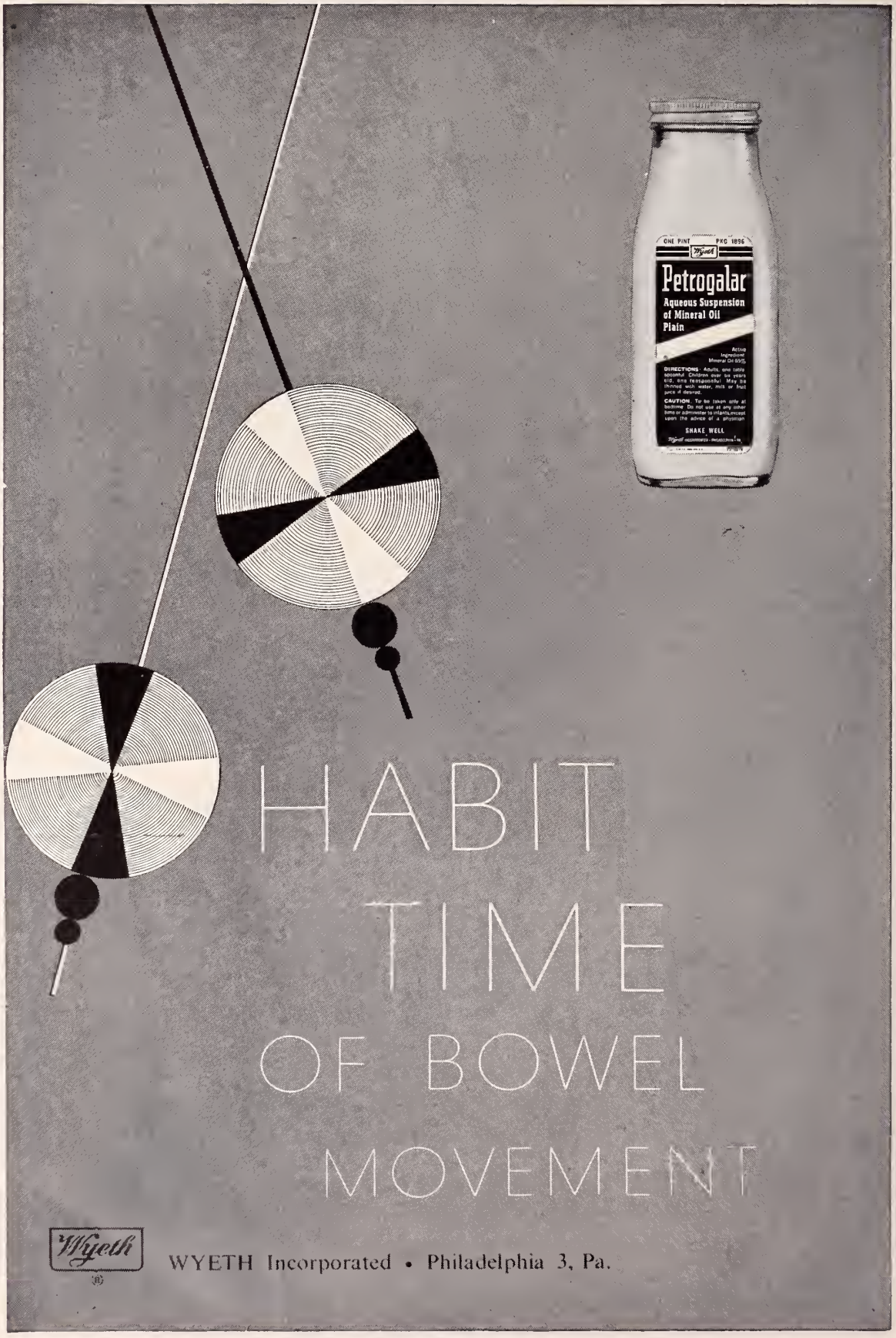
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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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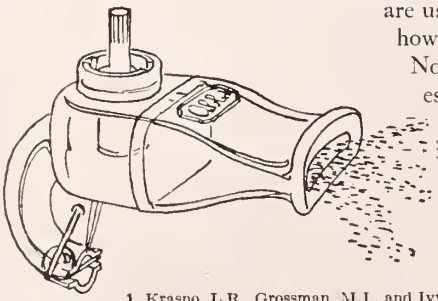

1. Krasno, L.R., Grossman, M.I., and Ivy, A.C. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March. 2. Krasno, L.R., Grossman, M., and Ivy, A.C. (1948), The Inhalation of Norisodrine Sulfate Dust, Science, 108:476, Oct. 29.

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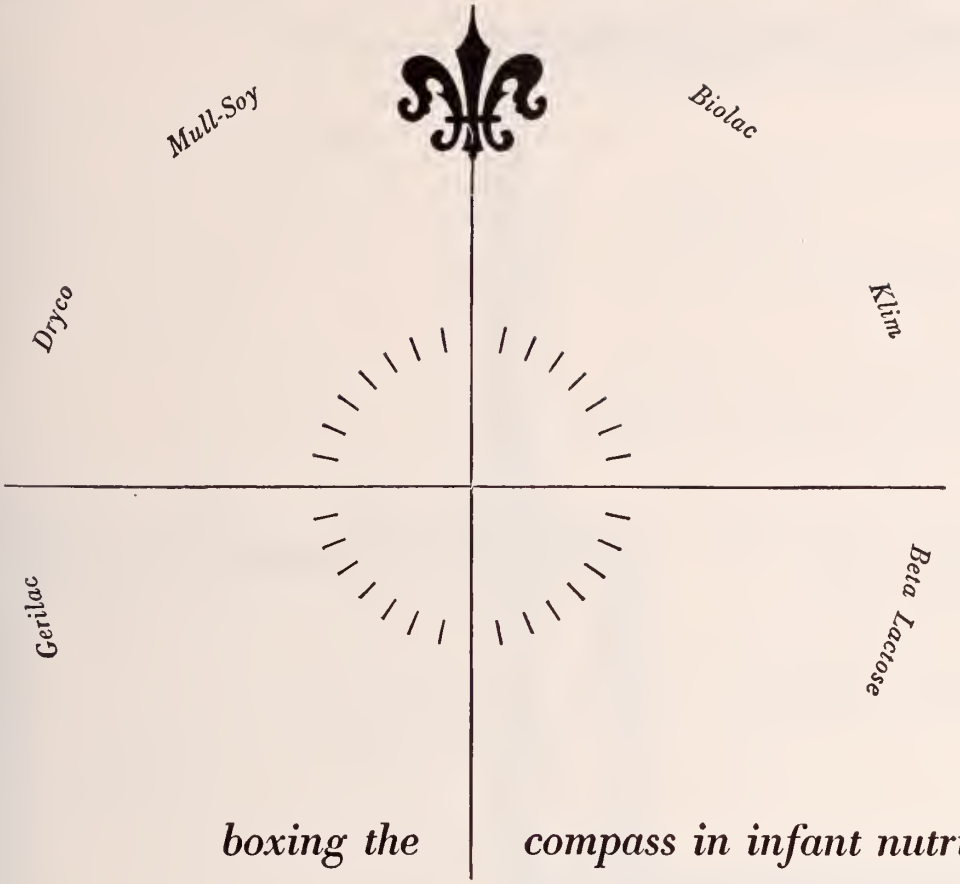

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« « « EDITORIALS » » »

Defective Hearing

It has been conservatively estimated that 50 per cent of the adult hard of hearing could have been saved this handicap if they had been seen early enough and properly treated.

It goes without saying, therefore, that the earlier we can discover the hard of hearing child, the greater chance we have of correcting the handicap. Not only is early discovery important from the standpoint of those children who have an impairment which can be corrected, but it is also important in those children in whom the hearing loss is not amenable to treatment. Rehabilitation of the latter group cannot be started too soon.

An otologist is often asked how soon treatment should be started in the hard of hearing child. It is felt that the sooner the impairment in hearing is discovered, the better. This means that as far as possible it should be done at the pre-school age.

There are certain signs that should make one suspicious even in children at the age of 1 year or 18 months. It is known that children who are profoundly deaf do not sit up as soon as normal children; they do not walk as early as normal children and even when they do walk there is a sluggishness to their steps. It is felt that this is due to the involvement of the vestibular portion of the eighth nerve.

Also, of course, these children are not disturbed by noises, and alert parents observe this very early.

Since it is not possible to check systematically on the pre-school child, it is imperative that we check the child in school to discover any impairment in hearing. Over a period of years there has been a number of hearing surveys in school children throughout the country. Until recently, these surveys did nothing but gather statistics on hearing defects in the schools. No follow-up work was done.

Previous to the last war, the American Academy of Ophthalmology and Otolaryngology, in an effort to have all surveys standardized, printed a syllabus on procedure. This is now followed throughout the country.

The Committee on Hearing Defects of the State Medical Society has worked for some time with the State Department of Public Instruction and the

State Board of Health trying to devise ways and means of checking the school children of Wisconsin.

In early 1947, Mr. Frank Powell of the Bureau of Handicapped Children in the State Department of Public Instruction, received funds from the Children's Bureau of the Federal Security Agency, which made possible the initiation of a survey of school children.

The objectives of the survey were not only to discover the child who had an impairment but to see that the child was referred to an otologist for treatment and also to maintain a follow-up system to see that the advice given was followed. The state now has a full time audiologist under the Department of Public Instruction who will go on invitation into any county or city to help organize a hearing program.

It must be understood, however, that the program is to be the community's responsibility, and it is expected that each year the program will be continued. Therefore, it is necessary that full cooperation be obtained from the doctors, public health officials, Parent and Teachers Associations and other civic organizations in a given community. The help of the state audiologist is also available as a consultant, even after the program has been inaugurated.

In 1947–1948 under this program 8,555 children were examined. In 1948–1949, there were 45,598 children examined. This year 1949–1950 it is estimated that about 150,000 children will be examined.

Whenever hearing defects are discovered, the child is reexamined more thoroughly. Then, all children who are found with an impairment are referred to an otologist if they have one, or special clinics are held in communities where this is feasible.

These clinics are conducted by otologists who have passed their board examinations in otolaryngology and are preferably from the community in which the clinic is held.

The follow-up work is done by either the school health nurse or the county health nurse. It is interesting that up to this time the advice as to treatment which these children receive has been followed in 95 per cent of the cases, which shows what can be done in communities with a whole-hearted cooperation of the medical profession and other agencies.

Besides the work that is spoken of above in the year 1948–1949, the State Board of Health, through Dr. Amy Louise Hunter, expressed a willingness to take on some of the examinations of these children. They selected for their survey the Eighth Health District, comprised of Langlade, Vilas, Taylor, Oneida, Marathon, Price, Lincoln, Forest and Florence counties. This is a very sparsely populated area where the problem was more difficult in many respects. It required far more general educational work. Every school child in this district has been examined, checked in clinics, and had follow-up work done on them.

Besides the above two programs there are a number of cities that have their own independent surveys, all along the lines of the above programs.

It is indeed healthy that we have in this state the full cooperation of our State Department of Public Instruction, our State Board of Health, our medical profession and the public helping in this important community health program. It behooves us, therefore, as physicians to cooperate fully in discovering the hard of hearing child and after the discovery to see that proper medical care is given and that the child is sent to whatever agency in the community that can assist in his or her rehabilitation.

I particularly wish to make a plea to all otologists to assist in the conducting of the medical clinics in their vicinity when called upon by Mr. Powell, of the Bureau of Handicapped Children. With the progress being made and with the hope of continued cooperation we feel that we are saving many children from the handicap of a severe hearing loss and in those children whose loss is not amenable to treatment, we will rehabilitate them successfully into their communities.—THOMAS L. TOLAN, M.D.

The Aged, the Infirm, and the Mentally Ill

In the colonial days, the mentally ill were housed in jails with criminals, and the poor were sold at public auction to the lowest bidder. As the country grew and civilization advanced, the poor people and mentally ill were housed in alms houses and poor houses erected by the counties in the various states.

In 1844, through the activity and influence of doctors and other charitable minded citizens, thirteen hospitals for the treatment of the mentally ill were erected in the eastern part of the United States. The success of these thirteen hospitals attracted the attention of public spirited people in the several states and marked the beginning of the construction of similar hospitals throughout the nation. Our state, following this example, built the Mendota State Hospital in 1860 and later the one located at Winnebago. The counties soon became interested in the construction of hospitals in which to care for these patients. The state refused to construct their hospitals, but to encourage the counties to construct their own the legislature authorized the sharing of the cost of the care of mental patients in the county hospital on an equal basis between the state and counties. The counties responded to this support and began to erect hospitals for the mentally ill. Out of this state and county cooperation our present system of medical care of the mentally ill has developed. The present system is composed of the two, Mendota

and Winnebago, State Hospitals where the acute and chronically disturbed patients are treated and 35 county hospitals in which the quiet undisturbed patients are domiciled.

The system is good but no system works unless it is administered to accomplish the purposes for which it is devised. Knowledge concerning mental diseases has changed our understanding of them since the concept for our system of institutions was devised; and while the system is good the methods used in their administration have fallen far short in many instances of accomplishing the purpose for which they are operated.

Through the years other public problems have arisen which impinge on the problems of care for the mentally ill. Two of these are as follows: (1) the problem of the mentally defective, and (2) the problem of care for old people. The counties in the beginning did not participate in the program of care for the mentally deficient. The state assumed this responsibility entirely and has continued in this role to the present time, with the notable exception of Clark County which constructed several years ago a large county mental disease hospital and was able to relieve the overcrowding in the Chippewa institution by taking some of the individuals from that institution. The problem of the aged and infirm is left without recognition by either the state or the counties except through a public assistance pension plan.

Because all three of these public problems were either neglected or poorly administered, the State Medical Society's Committee on Mental Hygiene and Institutional Care has made a number of recommendations to either the legislature, State Boards, or both, relative to them.

At the request of the Legislative Council the State Medical Society appointed a special committee to study the care of patients in the state institutions. This report was helpful in securing the funds needed to initiate a program of improvement. The last legislature allocated to the Department of Public Welfare close to $15,000,000 for new buildings and for the repair of some old ones, and money to improve the salary scale for the personnel. Most important in the last item was an increase in income for physicians and divisional directors that has made positions in these ranks more attractive to the quality and trained people that is so badly needed. The building program is well under way. A new $3,000,000 hospital for the treatment of patients with acute mental illness has been completed at Winnebago and the plans for a similar one at Mendota are ready to turn over to contractors for bids, and many other building projects are under way. The personnel problem is greatly improved for each of the institutions and consultation service for county hospitals will soon be available.

The problem of the aged is in a state of status quo. Our committee working with a committee of the County Judges Association has carefully studied this problem, and after many hours of consultation with public officials and other informed persons has drafted legislation to enable counties to construct infirmaries for the care of aged and infirm people. The bill provides that admission to the infirmary is not restricted to those who are unable to pay. Those who are able to pay are also to be admitted. It was in this manner that the accomplishment of a true home for the aged and infirm could be realized. There are many other desirable features to this proposed legislation which contribute to high standards of good medical care and cooperation between the state and counties in attaining these goals. It will be proposed again to the next legislature.

The present plight of our old people is pathetic. Whether they have money or no money they have difficulty to find places where decent care can be obtained. Not only can they not find the institutional care that they need, but neither can anyone be found who is willing to care for them at home.

During 1947 a survey was made by the Division of Public Assistance of the Department of Public Welfare of 247 commercial nursing and boarding homes for old people. There were 2,500 residents in these homes. The survey indicated that one-fourth of them did not meet *minimum* standards of care. Over-crowding, lack of proper fire protection and sanitation were chief among the undesirable features. And, although 35 per cent of the patients in these homes were bedridden, only 15 per cent of them were employing a registered nurse. In the survey there were 41 county homes with a population of 2,500. Half of these institutions were 50 years old, only 11 were of fireproof construction, and 22 were unsuitable in terms of modern standards of safety and sanitation. They needed more and better trained personnel, more infirmary type facilities, and improved medical care.

While the mentally ill have been removed from the poor house, the aged poor and some who are not so poor have followed them to the mental hospitals. The removal of the mentally ill from the alms houses, poor houses, and jails to a separate hospital facility of their own was a long pull and there is still much to be desired. We now have the long hard pull to remove the aged and infirm from the hospitals for those with mental diseases where they are now living because of no other facility.—H. H. CHRISTOFFERSON, M.D.

AMERICAN HOSPITAL ASSOCIATION TO MEET IN ATLANTIC CITY IN SEPTEMBER

The fifty-second annual convention of the American Hospital Association will be held in Atlantic City, N. J., September 18–21. Headquarters will be the Hotel Traymore. Meeting with the Association will be the Women's Hospital Auxiliaries, the Architects and State Planning Directors, the American College of Hospital Administrators, and the American Association of Nurse Anesthetists.

The Rh Factor in Pediatrics*

By TIBOR J. GREENWALT, M. D.
Milwaukee

T. J. GREENWALT

Doctor Greenwalt was graduated from the New York University College of Medicine in 1937. A diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians and the International Society of Hematology, he is the medical director of the Junior League Blood Center of Milwaukee, clinical instructor in medicine at Marquette University School of Medicine, and is on the staffs of Veterans Hospital, Wood, and Mount Sinai and Milwaukee County Emergency hospitals.

THE pediatrician is ordinarily asked to see the Rh-problem baby after it is born. It would be advantageous for him to acquaint himself with the family history and the events of the present pregnancy some time before the delivery date. He would then be better prepared to handle the situation adequately and promptly. We consider the erythroblastotic baby to be an emergency. The condition of the involved newborn infant should be evaluated right after birth and the course of treatment decided as soon as the necessary laboratory data become available. All too frequently the pediatrician does not arrive on the scene until too late. The situation of "too little, too late" should never apply, if we are properly informed and prepared.

The "science of Rh" has become too complex for most of us to follow. The villain Rh has been blamed for more mischief than he actually causes. I do not mean to under-rate his importance, but, for practical purposes it is sufficient for us to classify all individuals as either Rh positive or rh negative.

Six major Rh–Hr antigens are known (see table 1). $Rh_0(D)$, the original Rh factor discovered by Landsteiner and Wiener,[1] is the important one, because it is the most antigenic and the cause of over 90 per cent of the trouble with the Rh factor in pregnancy and transfusions. Individuals possessing $Rh_0(D)$ should be considered to be Rh positive. Those not possessing $Rh_0(D)$ should be considered rh negative as far as pregnancy and transfusions are concerned.

TABLE 1.—*The Six Rh–Hr Antigens with Their Equivalents in the Race-Fisher Nomenclature*

Rh_0 = D	hr_0 = d
rh′ = C	Hr′ = c
rh″ = E	hr″ = e

The three genes $R_0(D)$, r′(C), r″(E) exist in various combinations to form the eight major Rh types. The distribution of these eight Rh types is shown in table 2. It will be noted that approximately 85 per cent of individuals possess $Rh_0(D)$, and the remaining 15 per cent do not have it. Any individual, whether true rh negative, rh′, rh″ or rh′rh″, who does not have the antigen Rh_0, can be isoimmunized by it (see chart 1). An individual cannot be stimulated to form antibodies by an antigen which he possesses. Conversely, a specific antibody response can only be elicited by an antigen which the reactor does not have.

TABLE 2.—*The Distribution of the Eight Major Rh Phenotypes. Approximately 85 per cent of the Caucasian Population Possess $Rh_0(D)$*

	%
$Rh_1(Rh_0'$ or CDe)	54.0
$Rh_2(Rh_0''$ or cDE)	15.5
$Rh_1Rh_2(Rh_0'''$ or CDe/cDE	14.0
$Rh_0(D)$	2.0
	85.5
rh(cde) 13.0	
rh′(Cde) 1.0	
rh″(cdE) 0.5	
rh′rh″(rh_y or CdE) 14.5	very rare

Four anti-Rh sera containing anti-Rh_0 antibodies are available commercially (see table 3). Only the 85 per cent serum should be used for testing pregnant women and the recipients of transfusions. Otherwise individuals possessing rh′ or rh″ without accompanying Rh_0 will be considered Rh positive and the possibility of isoimmunization with Rh_0 will be overlooked.

$Rh_0 > rh' > rh''$

$Rh_0 \longrightarrow rh : rh' : rh'' : rh'rh''$

$\longleftarrow$ antibody response

Chart 1.—The Rh antigens are arranged in the order of the degree of antigenicity. Rh_0 antigen may stimulate antibody response in any individual not possessing it

An rh-negative woman should never be given Rh-positive blood by any route before or during the child-bearing period if isoimmunization and its effects on the fetus are to be avoided.

In man there are 24 pairs of chromosomes in each cell. The Rh characteristics are carried by one pair of these chromosomes. If both chromosomes of the pair carry the same factor, the individual is said to be homozygous for that factor. Otherwise he is hetero-

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

TABLE 3.— *These four sera are commonly used in Rh testing of pregnant women and the recipients of transfusions. Only the anti-D serum should be used for these purposes*

Anti-Rh_0(anti-D) serum	Reacts with approximately 85% of bloods
Anti-Rh_1(anti-CD) serum	Reacts with approximately 87% of bloods
Anti-Rh_2(anti-DE) serum	Reacts with approximately 85.5% of bloods
Anti-Rh_0''(anti-CDE) serum	Reacts with approximately 87.5% of bloods

zygous. All rh-negative individuals are homozygous, because rh negativity is a recessive trait. The fetus inherits one chromosome of each pair from each parent. Therefore, if the husband is Rh positive and homozygous, all the offspring will be Rh positive (see chart 2A). If he is heterozygous, 50 per cent will be Rh positive and 50 per cent rh negative (see chart 2B). Thirteen per cent of marriages are between rh-negative women and Rh-positive men. Only about 1 out of 20 rh-negative women bearing Rh-positive infants becomes isoimmunized. The incidence of isoimmunization increases with each succeeding pregnancy through the fifth. After that the incidence tends to decline.[2,3]

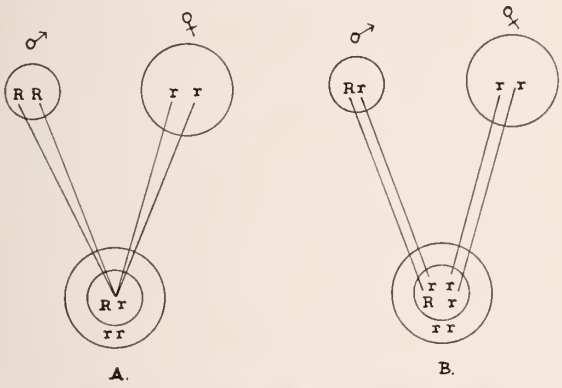

Chart 2.—*A*, all the offspring of a homozygous (RR) Rh-positive male and an rh-negative female will be heterozygous Rh positive. *B*, 50 per cent of the offspring of a heterozygous (Rr) Rh-positive male and an rh-negative female will be Rh positive. Fifty per cent will be rh negative.

It is important to test every rh-negative mother for the presence of anti-Rh antibodies early in pregnancy. Primigravida should be included because many are unable to give an accurate history of transfusions or injections of blood given during infancy or childhood. If antibodies are not demonstrable early, the tests need not be repeated until the fifth month, because antibodies do not usually appear for the first time until the fifth month. They are almost always present by the thirty-fourth week of gestation, if they are to appear at all. Whenever there is a history of Rh-incompatible transfusions or previous erythroblastotic infants, titers should be performed at monthly intervals and every two weeks during the last six weeks before term.

The clinical features of hemolytic disease of the newborn are well known. Serologic evidence demonstrating the presence of antibodies in the mother's serum antepartum and coating the red cells of the Streptococcus lactis are normally present in the infant after birth is essential for a positive diagnosis. Absolute reliance should not be placed on any other evidence. There are other conditions which may be associated with jaundice, anemia, erythroblastosis, or edema. The following have to be differentiated:

Physiologic jaundice
Prematurity
Birth trauma
Asphyxia
Congenital atresia of the bile ducts
Congenital syphilis
Congenital heart disease
Septicemia
Hemorrhagic disease
Idiopathic fetal hydrops
Hemolytic anemia, cause undetermined

The demonstration of antibodies coating the infant's red cells has been found to be the most reliable way to make a positive diagnosis. It is, therefore, important to collect cord blood in every instance. A simple slide test has been found reliable by the author. This is performed by mixing 2 drops of a 40 per cent suspension of cord red cells in their own serum or oxalated whole blood with a drop of 20 per cent bovine albumin on a glass slide. The preparation is rocked on the glass plate of a heated viewing box for five minutes and observed for clumping. The cord red blood cells may be washed three times in a relatively large volume of saline and then tested with anti-human globulin rabbit serum for the presence of adherent antibodies (globulin). This is the direct Coomb's or developing test.

Absolute reliance cannot be placed on the presence of jaundice, anemia, or erythroblasts in the peripheral blood stream, for cases are seen in which any one or all these features are absent at birth. Erythroblastosis fetalis is, therefore, a misnomer and should be supplanted by congenital hemolytic anemia of the newborn.

Prognostication on the basis of such inconstant features is necessarily hazardous. It is a multiplicity of unfavorable clinical findings which carries a bad prognosis rather than a single feature taken by itself (see table 4). The intensity of clinical jaundice by itself is not too helpful. The presence of more than 100 nucleated red cells per hundred white cells is serious; their absence is of no significance. Neurologic findings ranging from convulsions, opisthotonos, and spasticity to severe lethargy bordering on coma are not necessarily a bad prognosis as regards survival. Respiratory difficulty is of grave prognostic import. Mollison and Cutbush[4] have found that study of the cord blood is of greater value than capillary blood drawn after birth. They report that a cord blood hemoglobin under 8.0 Gm. and a cord plasma bilirubin over 4.0 mg. per hundred cubic centimeters point to an unfavorable prognosis. A cord hemoglobin over 15.0 Gm. and a cord plasma

bilirubin under 3.0 mg. per hundred cubic centimeters indicate a good outlook.

TABLE 4.—*Factors to be Considered in Determining Prognosis*

1. Intensity of jaundice
2. Edema
3. More than 100 nucleated red blood cells per hundred white blood cells
4. Respiratory difficulty
5. Neurologic manifestations
6. Cord blood hemoglobin level
7. Cord plasma bilirubin level
8. Degree of hepatosplenomegaly

Treatment would ideally be preventive. The inhibition of antibody formation in the mother or the neutralization of antibodies already formed is the goal. Rh hapten, which is material obtained by alcohol and ether extraction of Rh-positive red cells, has been used for the latter purpose. It is supposed to contain the specific portion of the Rh antigen separated from its protein and, therefore, is nonantigenic and incapable of stimulating an antibody response, but retains its ability to neutralize antibodies. Our experience does not indicate that Rh hapten as it is presently prepared and administered is of any value.

If the history indicates that the fetus has died in utero during the last month or two of a previous pregnancy, the termination of the present pregnancy prior to term should be considered. This should not be done before the end of the eighth month. The estimated size of the fetus is an important determining factor. It is not much of an advantage to have the hazards of too great prematurity added to those of erythroblastosis. The cord should be clamped promptly, so that as little of the mother's blood is pumped into the baby as possible. Every involved infant should be placed in an incubator under continuous administration of oxygen. Penicillin should be given routinely because of the high incidence of septic complications. It is wise to give vitamin K and to add methionine, choline, and inositol to the formula. Hypoglycemia has been reported as a possible cause of death in some of these infants by Zuelzer.[5] Blood sugar levels should be followed and treated as indicated. Breast feeding is contraindicated.

The type of transfusion therapy must be individualized. In the mildest conditions, patients may not require any transfusions. Some undoubtedly do well on multiple transfusions. Others require replacement transfusion.

If the baby is severely or moderately severely affected, replacement transfusion with rh negative blood, unless the problem is one of Hr, should be undertaken early. We have found the method introduced by Diamond to be the best. In this the exchange is carried out through a polyethylene catheter inserted into the umbilical vein. We have succeeded with this procedure as late as 40 hours after birth.

It is important to follow all Rh-positive infants born to isoimmunized rh-negative mothers carefully until the age of 3 months. In some of these babies a progressive anemia will develop as late as three months and occasionally four months after birth, regardless of the type of transfusion therapy employed in the immediate postnatal period. Weekly red blood cell counts and hemoglobin levels should be performed during this period.

There has been a good deal of concern regarding mental development and neurologic complications. Zuelzer[5] has found that there is little correlation between the early picture, the severity, and the eventual outcome. It is remarkable, however, that in all the cases in his series in which opisthotonos occurred in the newborn period signs of brain damage developed later. In 8 of his 25 cases such complications developed. The outlook is not quite as frightening as Zuelzer's findings would at first glance lead one to believe. This is because a number of the children in his group were brought back for study because of evident mental retardation. Of Mollison and Cutbush's[4] 50 survivors, in only 1 did signs suggestive of central nervous system damage develop. Of van Loghem's[6] series of 135 infants, in only 5 did sequelae of brain damage develop.

Evidence that hemolytic disease of the newborn may be a cause of simple feeble-mindedness is unconvincing. Mental retardation in association with other nervous manifestations is a known sequel.

Permanent liver damage also seems to be a distinct possibility; however, no conclusive evidence has been presented to substantiate this.

The Rh problem has been made too complicated by some to be of practical value. It has been blamed for many things of which it is innocent. Rh-negative women may have repeated abortions and retarded and spastic children for the same unknown reasons as their Rh-positive counterparts. Unless one can prove that Rh is involved by demonstrating antibodies in the mother's serum he should not be too hasty in frightening already anxious parents regarding future pregnancies. Even if Rh is the culprit, there may be a 50–50 chance for a normal rh-negative child if the husband is heterozygous—and 58 per cent are.

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Beta Ray Uses in Ophthalmology*

By ALBERT D. RUEDEMANN, M. D.
Detroit

A. D. RUEDEMANN

A diplomate of the American Board of Ophthalmology, Doctor Ruedemann is president of the Kresge Eye Institute in Detroit and serves as professor of ophthalmology at Wayne University College of Medicine. He graduated from the University of Michigan Medical School in 1921 and served a residency at the University Hospital, Ann Arbor, Mich. He has twice been honored by the American Medical Association for exhibits in his field.

OCULAR radiation therapy is not original with me. When we study patients in our offices, we realize that there are a few things which cannot be remedied. Among them are the diseases of the cornea and, of course, the central mascular diseases which cause economic blindness. Blindness in schools for the blind is different from the economic blindness that will reduce a man from a well-to-do individual to one who can just wheel a wheelbarrow or sell pencils. It is of interest because there are only 5 mm. of cornea that require leukoma or macular changes to produce economic blindness. The minute the pupillary zone is badly affected and vision drops down to the neighborhood of 20/100, such patients can no longer do the fine jobs that are required of them. About 15 years ago Doctor Loralaine, while at Minneapolis, did some work on the use of gamma rays with corneal leukoma. Since then my associates and I have treated corneal lesions on the lid with gamma rays, although men using x-ray and radium were afraid of producing cataracts. This fear is unwarranted because patients with diseases of the cornea usually have lenticular opacities anyway.

Some 10 years ago at Johns Hopkins, Doctor Woods published reports concerning the treatment of ocular tuberculosis with beta irradiation. At that meeting I was impressed by the beautiful results which they obtained in comparison to the poor results I had seen from tuberculin and general supportive measures. The radium at our clinic was under the control of the departments of surgery and radium, where they were so busy treating various carcinomas that we had a difficult time getting radium for lesions of the eye.

Any type of radiation therapy is useful, but radiation treatments are destructive therapy. When swapping horses one starts by figuring whether the swap is for an eventual benefit. A destructive mechanism may be too great for the eye and may throw the patient into a decline even worse than the original disease. It should be remembered that x-ray, beta and gamma rays of radium, radon emanation, or radium-D all may produce secondary responses which are worse than the original disease.

Contact x-ray is very successfully used in lid lesions, and gamma rays are much better than beta rays on plushy lid lesions; because the beta rays are 2 mm. rays, they do not penetrate deeply. If they are used, however, over long periods of time they have accumulative effect. If the beta rays are used for long periods of time in heavy doses, effects occur up to 4 and 5 mm. and over a much wider area. The time factor is important.

Recently at a meeting the use of radon in preference to radium-D was discussed. Radium-D is a degeneration product of radium which has a life cycle of about 25 years. It is not as powerful as radon. Radon gets a great deal of its strength because it is made up of gamma and beta and alpha rays. Alpha rays are screened by the glass tube, and 97 per cent of the beta rays come through. In using a radon applicator having 250 millicuries, the treatment time is about 20 seconds. In that treatment 3 per cent is gamma radiation. I am quite convinced that the gamma rays have certain effects not obtained with radium-D. Radium-D applicators of 10 millicuries, as advocated by Swanberg, are not strong enough, because the treatment time is so long. It goes up in the neighborhood of five, six, seven, or eight minutes, according to what one is trying to treat, and is of no value in the treatment of epithelial overgrowth on the lid margin. Radium-D works nicely for corneal lesions. Treatment times up to three or four minutes are not important except in very young children. Now if one is treating lid epithelioma squamous overgrowth, he must go to gamma rays or contact x-rays. Some small superficial overgrowths of the lid or the inner surface of the lid can be treated with radon or with the stronger radium-D applicator, but the 10 millicurie applicator is not of much value.

As to the treatment of these lesions, I would say, first, that wherever there is corneal vascularization, there is a patient who is in trouble; he is uncomfortable, and radium applications many times will reduce such vascularization of the cornea. Another very important point in regard to radiation therapy is that the eye responds as two separate parts; one is the sclera, cornea, lens, vitreous, and aqueous; the other is the uveal tract and retina. People with a tremendous loss of vision because of corneal dystrophy opacity may be raised from the level of counting fingers or moving shadows to 20/200 and thereby be benefited very materially. Third,

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most of the patients for whom corneal transplantation has been advised will refuse surgery because of the improvement in vision. Of course, the patient is satisfied in regard to his visual recovery, and it is vision that we are after. This is called the marginal zone of ophthalmic practice, because none of the ophthalmologists have had anything to offer heretofore.

Treatment time is not directly proportionate to the amount of millicuries in the applicator. Treatment time is subject to the density of the lesion being treated and what can be expected of it.

Objectionable epithelial overgrowths along the lid margin can be treated with contact x-ray, gamma rays, radon applicators, or radium-D. Radium-D rarely causes epilation because it is not penetrating enough, although a great many treatments are not required. Again, these marginal epithelial overgrowths which become cancerous can be treated with radon. The normal lid margin is retained without notching. I would like to say that my associates and I have not treated any lid cancers by operation in the last 25 years. We use gamma rays, contact x-rays, or the very thinly penetrating beta rays.

In the treatment of the polypoid degeneration of the lid in vernal catarrh, we treat the early cobblestones with gamma rays or contact x-ray. One treatment will make the patient comfortable. It is the small isolated polyps on the undersurface of the lid that are important, because they cause discomfort and possible corneal scarring. These individual polyps can be treated. If they are very large and fibrotic, they may be excised and the membrane treated, but the membrane will improve more under radiation than it will by excision or any other approach.

If these excrescences are removed and studied pathologically, they are found to have the same structure as a polyp. If the membrane is not too bad, it will return nearly to normal. Of course, the source of the trouble must be investigated, which is very difficult in cases of vernal catarrh. The source of their irritation may be quite simple—some substance with which the patient is coming in contact early and frequently, the early pollens, the early trees, and things of that sort. Polypoid degeneration of the lid is well handled by gamma, beta, or contact x-rays.

Concerning the region of the cornea, one sometimes finds a marginal lymphogenous overgrowth that is usually due to allergy. Patients with such a condition are made comfortable again with one application of radium-D. Although these people are made comfortable within 8 to 10 hours of the first application, and can have combinations of antistine, privine, or carabenzoine to carry on their comfort, one must find the basic cause or expect many recurrences.

Now interestingly enough, I shall interject this line of confusion regarding an individual who had a marginal disturbance of the eye. The patient was one of the few that we thought to have a pure vitamin A deficiency. He had photophobia, lacrimation, and blepharospasm. Beta radiation, except for any corneal vascularization, is of no value in vitamin A deficiency.

The type of lesion that responds rapidly to radium is a superficial corneal overgrowth that has capillaries with superficial vessels going into the cornea. After an attack of severe conjunctivitis with vascularity one or two applications with a radium applicator will get rid of the superficial vascularity and make the patient very comfortable. Again it is the vascularization of the cornea that leads to their discomfort.

Corneal nebulae always produce loss of vision out of all proportion to their density. If treated with radium, the patient becomes comfortable quickly, and in most instances his vision improves. This is easily done by radium. Grenz rays are much too soft, and gamma rays do run the hazard of producing cataract. As I mentioned before, the eye is two distinct organs and many people who have anterior segment disease never have any other reason for their visual loss.

Dermoids in the margins of the cornea, occurring in children, can be reduced to a porcelain white scar. Infants can be handled without anesthetic, providing there are five, six, or seven people in the office to hold them down. Whenever the white color of the lesion is reached, the irradiation is sufficient. Beyond this a degenerative process is caused, which may seriously affect the eye.

A baby cannot be treated with contact x-ray or two gamma rays for 15 or 20 minutes. One has good control of the applicators when using radon, because the treatment time is in the neighborhood of 10 to 20 seconds. Treatment times of two or three minutes, using the softer radium-D, take too long.

In a case of cancer along the margin of the eye, again treated with radium-D, we completely obliterated the vascularization of the lesion. To this day there has been no indication of recurrence. I know of no other way to remove such lesions, destroying the process, and have the eye return to a fairly normal state.

A common case of limbal teratoma was treated for a long while without any retardation of growth. We excised it, treated the base with radon, and got a fairly clean eye. This brings out a very important point. If it is possible, the pupillary zone of the cornea should be uncovered and the patient left a little eyesight, even if only a pin point. There are interstitial infiltrations of plasma cells and fibroblasts that are destroyed with applications of radium so that the cornea clears.

In a very severe teratoma that practically covers the entire cornea, one can do a keratoplasty, peel it off, and then treat the base with radium. A fairly decent looking cornea can be expected.

In another case marked vascularization extended on over into the cornea. Such a condition is treated until the lesion has a white appearance. There is such a thing as overtreatment with beta rays;

a true beta radiation carcinoma results if treatment is too long or too frequent or over too long a period.

Marginal overgrowths, called pterygia, can be treated with radium alone when in early stages but only postoperatively if they are well developed.

Pseudopterygia are difficult and can be operated on repeatedly, providing good practice for different types of pseudopterygian surgery, but after a while the mucous membrane transplants are worse than they were originally. Now, basically, these pterygia develop complete vascularization that goes through interstitial tissue up into the cornea, and the lesion grows back from the cornea to the margin, as well as from the margin out to the center of the cornea; this requires treatment of the margins to get the deep vessels, as one cannot get rid of them surgically.

Next, when an individual is extremely uncomfortable because of a burn from a firecracker sharp and strong enough to burn into the cornea, there is no help to be offered, because of the replacement fibrosis. Wherever normal tissue is replaced by a definite scar the area cannot be improved with radium, but the comfortable vascularization can be cleared up with contact beta therapy and the patient encouraged to accept his disease. There are two ways of treating corneal lesions: one, by constant moving of the applicator over the cornea and spraying the minute capillaries or, two, by putting the applicator directly in contact with the lesion for a minute or two. As I said before, if one can get rid of a portion of the lesion over the pupillary zone, so that the patient can look through, he will be entirely comfortable.

Recently we had a lesion similar to this produced in a man who got his exercise by going to a masseur. In the course of the treatment, the patient's cornea had been scratched with a finger nail; an eye was lost. Seventeen years later he came into the office complaining of discomfort, photophobia, and inability to work because the remaining eye bothered him. This man did not have traumatic neurosis; he did not need psychosomatic medicine. He was uncomfortable. We treated his cornea twice with beta radium. A year later he returned to state that he had been entirely comfortable.

On the cornea, it does not make any difference whether the vascularization is superficial or deep; we treat it. Old lesions can be treated years after, as long as the blood vessels are still pliable and still carrying blood. At times vision is improved too. I do not know whether it is due to the transference of light into heat by its absorption in these vascularized and nebulous corneas, but I know that these people are usually photophobic.

Beta radiation helps in any number of cases of interstitial keratitis in which the vessels are still carrying blood. We had one patient who had had interstitial keratitis for six years; he was operating a newsstand. We treated him over a period of time, and the last time I saw him he had driven his car to Florida and back and had changed his position. If economic sight can be restored so that patients can earn a decent living, it is really worth while. Interstitial keratitis of syphilis, tuberculosis, or any of the other systemic diseases are definitely benefited by this treatment.

A corneal leukoma can be reduced in extent to provide a clear zone of cornea around it by irradiating the peripheral vascularizations prior to corneal transplantation. The success of corneal transplants depends on the amount of subsequent vascularization. If they become highly vascularized the cornea can become opaque and nothing can be done about it.

One of these patients with diffuse corneal lesions, interestingly enough, would not lend himself to corneal transplant because he was satisfied with the vision he got after his radium application.

Corneal dystrophies are not helped a great deal by radium. It is used in the corneal lesions that are vascularized or those corneal lesions that have infiltrations of new cells. Lesions such as these can definitely be helped with radium and by cutting out the vascularization; if the condition does not otherwise improve some can have corneal transplants. In the end stage of some cases of corneal dystrophy we have recently tried to get some patients ready for corneal transplant by getting rid of the corneal vascularization. Unfortunately, our corneal transplants in these have been 100 per cent zero. They are poor because of two very important reasons: first, they have practically no lacrimation; and second, the minute one gets rid of the vascularization they do have and then performs a transplant, there is not sufficient nutrition to keep the transplant alive and it degenerates almost as quickly as it is put in. As a matter of fact, we had one where we put the second transplant in while the patient was in the hospital.

Such patients can be treated with radium. This leukomatous scar can be destroyed or diminished to its minimum size and then, if necessary, a corneal transplant can be put in. Four to five millimeter transplants cannot be put in with any degree of success; very large transplants have to be used. We are using those in the 8 or 9 mm. group and sewing them directly into the cornea and then treating them afterwards with radium to keep out the vascularization. With that treatment a central zone is kept fairly clear.

Dense corneal leukomas, which were heretofore not operated on, can now be treated with radium and diminished to their minimum size; then later, transplants of clear cornea can be used with a certain degree of success.

It is in this group that I think we have a new field of transplantation surgery. I want to emphasize alkali burns, which are extremely destructive. First, they penetrate the cornea and change the chemistry of the aqueous and the lens, leading to cataract formation, iris changes, and persistent degeneration of the globe, with subsequent secondary glaucoma and eventually phthisis. But there is a second factor. The same process that destroys the cornea destroys

all the goblet cells on the conjunctival epithelium, interfering with normal secretion, so that there is no longer mucin or sebum around the eye. If in the initial treatment one substitutes some of the mucous membrane of the mouth and adds to that some bland ointment such as is obtained with one of these salves, ointments, or substitute cellulose tears, such people can be made more comfortable. I think that it is not moisture that these people require but a smooth mucin or waxy surface over the cornea and the conjunctiva to protect them.

Sulfur dioxide burns due to freezing substances in a refrigeration system cause an alkali burn that is persistently degenerative and leads to marked vascularization, photophobia, and lacrimation. We help these people by ending the corneal vascularization.

Acid and metal burns are better in regard to end results. Once the acid is neutralized, the burn does not progress. I had a patient who fell in a vat of concentrated hydrochloric acid. When he was hauled out his clothes dropped off; he lost most of his skin by first degree burns, but he had some second degree burns on his face, and he lost his corneae. By doing a keratoplasty and treating his cornea with radium to keep the vessels out, we enabled him to get around and he has another job in the industry. Metal does exactly the same thing. A granulomatous overgrowth can be excised and the base treated with radium.

A patient with a severe fibrosis of cornea due to lues, a porcelain-like fibrosis of the cornea, is getting a zone of clearing with beta rediation therapy. I do not believe that beta radiation can be used any further in this individual, because there is a fibrosis of the cornea. With the margin inside the subclear zone of the cornea, I think we can take a chance on transplanting a cornea there at 9 mm. with the hope that enough of the cornea can be kept clear so that it will regenerate in time. If the cornea regenerates in scar tissue it is of no value, but if it will replace corneal tissue with endothelium and the substantia propria will regenerate, the new cornea will replace itself in time.

In the case of a lime burn (it was the man's only eye; the other had been burned out completely), we treated the margin, got rid of all the vascularization, and then did a large corneal transplant which has been maintained now over a period of five years; however, he has a nuclear cataract, a central opacity. He is not concerned with that, since he is able to do his job. We could not have transplanted this cornea in the ordinary lime burn or alkaline burn with any degree of success.

Conclusion

I should like to repeat what can be done with radiation therapy. First, heavy dense lesions of the lid are best treated by contact x-ray therapy and gamma rays. Other therapies, such as radium-D or radon, do not penetrate deeply enough and the treatment time is too great. Radon in the treatment of corneal lesions is better than radium-D because, again, a youngster cannot be held still long enough. When one gets down to treatment time of 10 to 20 seconds, it is possible. When one gets up in the treatment time of two and three minutes, nobody can hold them still. The treatment time factor is very important in infants, and this is where radon is tremendously important. In the adult group, radium-D applicators as put out by the Canadian Radium Corporation, even the 10 millicurie ones, are strong enough if they are applied long enough. Again, the treatment time factor is so great that one gets tired of holding them.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY ANNOUNCES CHANGES IN REQUIREMENTS

New Bulletins of the American Board of Obstetrics and Gyencology, incorporating changes made at the meeting of the board in Atlantic City, N. J. on May 21–27, are now ready for distribution. These changes include the adoption of a special form to be designated as the "Appraisal of Incomplete Training Form," which will be forwarded to prospective applicants upon request. Numerous changes concerning graduate training in obstetrics and/or gynecology have also been adopted and will be of special interest to hospitals conducting residency programs as well as to prospective applicants to this Board.

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States and Canada on February 2, 1951. Application may be made until November 5, 1950. Application forms and Bulletins are sent upon request to Paul Titus, M. D., Secretary, American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

Roentgen Therapy of Cavernous Hemangiomas*

Report of a Case Complicated by Secondary Infection

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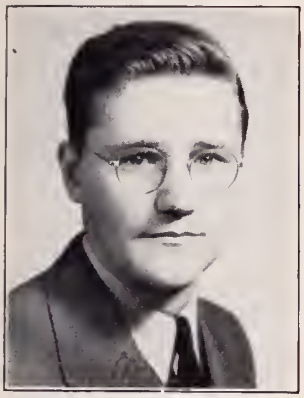

J. H. JUHL

Doctor Juhl graduated from the University of Michigan Medical School in 1940. Following internship at the State of Wisconsin General Hospital and two years in private practice, he entered the United States Navy. Following his discharge from the Navy, with the rank of lieutenant, in 1946, he completed a residency in radiology at the State of Wisconsin General Hospital where he is now an instructor in radiology.

E. A. POHLE

Doctor Pohle received his medical degree from the University of Frankfort on Main (Germany) in 1921 and a Ph. D. in biophysics from the University of Michigan in 1928. After serving on the staff of the University of Michigan Medical School, he joined the staff of the University of Wisconsin Medical School as professor of radiology, chairman of the department of radiology, and radiologist to the State of Wisconsin General Hospital.

Introduction

RADIATION therapy of vascular nevi of the skin and subcutaneous tissues has been largely limited in the past to the use of radium[4, 5, 6] although roentgen rays have been employed by some radiologists. Since these angiomatous tumors are treated in infancy and early childhood, the agent of choice is necessarily one which can be most readily applied. Radium plaques and screens meet this requirement; they are held firmly in place by adhesive tape without difficulty and the child does not need immobolization during treatment.

A few authors [1, 2, 4, 7, 9] have related their experience with roentgen therapy in these lesions. Spencer[9] reported a series of 19 cases in which the patients were treated by high voltage roentgen rays, with satisfactory regression in 18 of them. Most of the patients in his series had been followed for relatively short periods of time, but several had regressed completely and the others were improving. His technic was 200 kilovolts, 0.5 mm. of copper filter, 20 cm. FSD†, 200 roentgens (in air) for one to five treatments at intervals of two months.

Prouty[7] reported a series of 129 cases in which the patients were treated by roentgen rays, with results as follows: (1) excellent (minimum scarring, complete disappearance of tumor mass and color) in 87; (2) good (complete disappearance of tumor but with a few residual vessels or a little scarring) in 27; (3) fair (some color, scarring and residual tumor) in 8; and (4) poor in 4 cases. His doses were higher than those of Spencer; they varied from 300 to 600 roentgens (in air), but he used unfiltered roentgen rays produced at 80 and 135 kilovolts.

There are certain large lesions which lend themselves to roentgen therapy because of their size and location. It is possible to get more even distribution of roentgen rays than of beta and gamma rays of radium in these cases. This eliminates the irregularity and blotchiness which may follow uneven irradiation when radium is used on large irregular areas which require several applications to cover the entire vascular tumor. It also eliminates the possibility of overlapping in some cases. The chief difficulty in the use of this method is in the immobilization of the patient.

Technic of Treatment

The area surrounding the tumor is first protected with lead, a hole having been cut in a lead shield which will permit exposure of the lesion and a very small rim of normal tissue (2 mm.) around it. The latter is done to insure the treatment of the edge of the nevus. The lead shield is then firmly taped in place; when this is accomplished the patient can be immobilized sufficiently by being wrapped in a sheet or held by a parent or attendant to permit treatment.

"Contact" roentgen therapy has been used in the treatment of hemangiomas by several radiologists[1, 2]. The dosage varies with the authors, but in general it is from 200 to 400 roentgens (in air) per treatment at intervals of four to six weeks. The usual factors are 45 to 60 kilovolts, 4 milliamperes, inherent filter, 0.2 mm. of nickel with the HVL† equal to 2.4 mm. of aluminum, 3 to 5 cm. FSD. The percentage depth

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† Focal skin distance.

† Half value layer.

dose varies from 60 to 25 per cent at 1 cm., with a target skin distance of 5 cm. to 3 mm.[3] Satisfactory results have been reported; we have had no personal experience with this method.

The depth of the tumor is the determining factor in selecting the quality (penetration) of radiation used by us. For relatively superficial hemangiomas we employ roentgen rays generated at 130 kilovolts with a filter of 0.25 mm. of copper plus 1.0 mm. of aluminum, HVL equals 0.35 mm. of copper. A dose of 150 to 200 roentgens (in air) is administered at intervals of two weeks for a total of three to five treatments. The patient is then examined in four to six weeks following the last treatment, and a second series may be given if the lesion has not regressed enough to produce a satisfactory cosmetic result.

For large deep cavernous nevi we use 175 kilovolts, a filter of 0.5 mm. of copper plus 1.0 mm. of aluminum, HVL equals 1.05 mm. in copper. Treatment intervals and total doses are similar to those given above.

History of a Case

J. H., a girl aged 4 months, was first examined as an outpatient in the department of radiology at the State of Wisconsin General Hospital on May 31, 1947. The child had been born with a "red birth mark" on her right wrist and forearm, and no treatment had been attempted prior to her visit here. Physical examination revealed a large cavernous hemangioma extending almost completely around the lower forearm and wrist, with only a small uninvolved area on the medial aspect. It extended from the level of the first metacarpophalangeal joint upward to involve the lower one third of the forearm on its lateral, dorsal, and ventral aspects (fig. 1).

A series of four treatments of 200 roentgens (in air) each was given to the hemangioma at intervals of two weeks. Because of the location, two portals were used, one anterolateral and one posterolateral. The factors were: 130 kilovolts, 5 milliamperes, 15 cm. FSD, filter 0.25 mm. of copper plus 1.0 mm. of aluminum, HVL equalling 0.35 mm. of copper; intensity was 80 r per minute. Approximately two weeks following the completion of the treatment the child fell, injuring the arm at the site of the lesion. Infection followed, with ulceration of a major portion of the area involved by the hemangioma. The ulcerated areas were treated with Macey's ointment* and the ulceration had partially healed when the patient was examined on Sept. 6, 1947 (fig. 2). Two weeks later the ulceration had healed completely and the lesion was regressing well. When the patient returned for checkup on Jan. 24, 1948, the hemangioma had disappeared almost completely (fig. 3).

The final examination was on Jan. 29, 1949, at which time the cosmetic result was felt to be entirely satisfactory (fig. 4).

Comment

As pointed out before, we use radium in the treatment of the majority of hemangiomas amenable to irradiation. However, roentgen rays have a definite place in this field. From experimental and clinical evidence we may deduce that the biologic effects of these two agents are identical for equal amounts of radiant energy absorbed. Consequently it is not surprising that good results may be obtained by the proper use of roentgen rays. The secondary infection which occurred in the case presented here contributed in our opinion to the final result; we have seen

* Haliver oil 10 parts, cod liver oil 50 parts, 10 per cent zinc peroxide in white petrolatum 100 parts.

Fig. 1.—Appearance of hemangioma before treatment on May 31, 1947.

Fig. 2.—Appearance of hemangioma on Sept. 6, 1947, showing partial subsiding of the infection and response of the lesion to treatment.

Fig. 3.—Photographs taken on Jan. 24, 1948, show that the ulcerated areas have healed over; no further radiation therapy was required.

Fig. 4.—Follow-up study one year after photograph shown in figure 3 was taken. The patient was discharged.

this happen in a sufficiently large number of patients to become convinced that secondary infection may hasten the disappearance of the lesion. As a matter of fact, hemangiomas secondarily infected at the time treatment is started require smaller doses than noninfected ones.

Both roentgen rays and radium are apt to retard growth, especially in young persons, provided that sufficiently large doses are administered. It is not astonishing, therefore, to meet occasionally a certain amount of reluctance on the part of the referring physician if the hemangioma is located near an epiphysis. Reports in the literature based on both experimental and clinical observations indicate that this possibility exists[8]. However, in the twenty year period during which we have used the methods described elsewhere[6] and in the section on "Technic" not a single instance of growth retardation has been observed by us, although we have had ample opportunity to re-examine many of the children treated as long as five years and later after therapy.

Summary

1. The treatment of cavernous hemangiomas by roentgen rays and radium is briefly discussed.

2. A case of a large lesion of this type complicated by secondary infection and treated successfully by roentgen rays is reported.

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Some Practical Considerations in the Problem of Carcinoma of the Rectum and Lower Sigmoid Colon*

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A graduate of the University of Toronto Faculty of Medicine, Doctor Gray spent seven years interning at the Toronto General Hospital and in England before joining the surgical staff of the Women's College Hospital, Toronto, in 1941. Since January 1946 she has been the chief surgeon at that institution and is also a clinical teacher in surgery on the University of Toronto Medical Staff and an associate professor of surgery in the University of Toronto Dental College.

THE current medical literature contains many fine papers on carcinoma of the rectum, in which the problem of this dread disease is discussed in a very scientific manner. The authors of these articles, however, have a tendency to concentrate on certain specific aspects, such as the proof of the direction of the lymphatic spread or the advantages and disadvantages of special operative procedures in the surgical therapy. These papers are of value chiefly to the surgeon who is specializing in proctology. There would seem to be room in the literature, therefore, for a more simple discussion of carcinoma of the rectum and lower sigmoid colon, in an attempt to emphasize certain points in diagnosis and treatment which may be of everyday practical use to the general surgeon who does not consider himself a specialist in rectal lesions.

Because of its insidious onset, carcinoma of the right side of the colon is frequently first diagnosed at an advanced stage. The fluid character of the content of the proximal large bowel and the fact that carcinoma in this portion of the colon is most commonly polypoid in type result in absence of symptoms and signs of increasing mechanical obstruction. Moreover, bleeding from the tumor is frequently not noticed by the patient, because the blood is well mixed into the fluid stool. The early signs and symptoms of a little increasing weakness and fatigue, and possibly a slight loss of weight, are often attributed to secondary anemia. Some increase in the frequency and fluidity of stools may be so minimal as to be overlooked.

In contrast to malignant growths of the proximal colon, carcinomas of the left side of the large bowel produce such characteristic symptoms and obvious signs that their early diagnosis should be a simple matter. The content of the left side of the colon is solid and the gross pathologic type of malignant lesion here is most commonly scirrhous and stenosing. Hence, gradually increasing constipation, going on ultimately to frank obstruction, and the obvious presence of blood on the surface of formed stools are prominent features. Moreover, the majority of carcinomas of the left side of the colon occur either within reach of the finger on rectal examination or within the range of vision of the sigmoidoscope. When a neoplasm is present in the distal colon, the x-ray findings following barium enema are usually quite obvious and characteristic. In marked contrast is the difficulty of x-ray demonstration presented by the small polypoid lesion occurring in the roomy, pliable, and fluid-containing cecum or ascending colon. Yet, despite all these characteristics of carcinoma of the left side of the large bowel, which should facilitate its early diagnosis, many cases of malignant growth of the descending colon, sigmoid, and rectum are still being first recognized at a stage of the disease which is far from early.

In some cases it is the patient himself who is responsible for this delay. The sedentary habits, fast tempo, and refined foods of our modern civilization have resulted in the majority of our population suffering from some degree of constipation. The very number of different laxatives and cathartics, and the ubiquity of their advertisement, is evidence of the frequent incidence of this complaint. It is not surprising, therefore, that many patients accept a certain degree of constipation as their natural lot, and either fail to notice a gradual increase in the amount of laxative which they require or else attribute it to advancing age. The other handicap which delays the layman in reporting to his physician is the frequency with which rectal bleeding is either unnoticed by the patient or else is attributed to simple hemorrhoids.

There is no doubt, however, that the patient himself is not always solely responsible for the delay in cases of late diagnosis of carcinoma of the left side of the colon or rectum. It must be confessed that a portion of the blame rests with the medical profession. Too often the physician fails to investigate adequately the middle-aged patient who complains of a change in bowel habit. It is obvious that every such patient cannot be asked to accept the cost of x-ray investigation. But the benzidene test for blood in stools is very simple and inexpensive and can be carried out in any doctor's office. Persistently posi-

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

tive results in tests for blood in the stool provide a definite indication that complete investigation of that patient is not only justified but absolutely necessary. Moreover, physicians as well as patients fall into the error of attributing rectal bleeding to hemorrhoids, particularly when obvious congestion of the hemorrhoidal venous plexus is present. This is a mistake which will be eliminated only when every patient who presents rectal bleeding which did not first appear in his youth is subjected to complete investigation by digital rectal examination, sigmoidoscope examination, and x-ray following barium enema before hemorrhoids are accepted as the sole source of the bleeding.

Sigmoidoscopic examination is the portion of the investigation which is most often overlooked. Yet it constitutes a very essential step. Radiologists are the first to admit that x-ray often fails to demonstrate lesions which are within 7 to 8 inches of the anus. The finger on rectal examination frequently will not reach tumors which are more than 5 to 6 inches above the anus. Therefore a carcinoma situated 6 or 7 inches from the anus may be missed by both barium enema and digital rectal examination. It has been estimated that as many as 20 per cent of all malignant growths of the large bowel occur at this very site, and possibly half of these may be overlooked if sigmoidoscopic examination is not carried out.

Mistakes are sometimes due to misinterpretation of the history. Any lesion at the rectosigmoid junction or in the rectum proper will be treated by the bowel as a foreign body, and this often results in increasing frequency of desire to defecate. The patient may go to stool several times a day to strain and pass small amounts of solid feces. Many laymen describe this as "diarrhea" and will flatly deny constipation under these circumstances. Hence it must be emphasized that *any* change in bowel habit, whether of frequency or consistency, volume or shape, of stool, must be considered as significant, particularly when such a change makes its onset in a patient who is middle aged and when it persists for more than a very short time.

The position of the patient at the time of digital examination may have a great effect on the accessibility of a growth in the rectum to the examining finger, particularly if the carcinoma is still mobile or is of the pedunculated polypoid type. In the knee-chest position the curves of the rectum tend to be straightened out and the mucosa slides upward, so that in this position digital rectal examination may fail to reach mobile lesions which are readily palpable when the patient is examined lying on his side. In many instances it may even be worth while to carry this principle a little further and have the patient squat in order to examine him in the upright position. Gravity will then slide the redundant mucosa downward and may bring within reach of the examining finger a mobile polypoid carcinoma which could not have been felt digitally in any other position.

Once a diagnosis of cancer has been established, the patient's first question is usually as to his chances of being cured. This question is no easier to answer in cases of malignant growth of the terminal large bowel than in carcinoma anywhere. We know that polypoid lesions are, on the whole, less malignant than the scirrhous infiltrating type. Moreover, the patient with a small mobile tumor is, generally speaking, more amenable to cure than one with a large fixed growth. Marked loss of weight is an ominous sign in so far as it frequently indicates the presence of metastases in the liver. Still there remains that unknown factor about carcinoma which results in surprises. The patient with what seems to be a very advanced malignant growth, the removal of which would appear to be a palliative procedure, sometimes lives for many years after the operation. On the other hand, we not infrequently resect a small early tumor in the real hope of curing the patient, only to be disappointed to find evidence of the existence of blood-borne metastases within a few months of operation. It is this unknown factor about carcinoma, which seems to be completely unrelated to morphologic cell type or gross pathologic form of the lesion, which prevents us from being too optimistic about even the earliest malignant growth and which also makes us reluctant to give up the more advanced tumors as inoperable.

To the patient, second in importance only to the saving of his life from cancer is the question of whether he can be cured without having to have a permanent colostomy. The wise practitioner can, of course, avoid answering this question by referring it to the surgeon to whom the patient is being sent. But the surgeon who is responsible for the operative therapy of the patient must be possessed of some very definite knowledge as to what type of patient must be submitted to total extirpation of the rectum in order to achieve the best results, and under what circumstances consideration may be given to the possibility of preserving the anal sphincters without prejudicing the patient's chances of being cured of cancer. The basic principle of all operations for carcinoma anywhere is that the resection shall include not only the primary growth with an adequate margin of apparently normal tissue all around it, but also as wide a segment of the field of lymphatic drainage of the tumor as is surgically and anatomically feasible. Therefore, in any particular case of carcinoma of the rectum the advisability of an attempt at sphincter preservation will depend on two factors. The technical possibility of resecting an adequate margin of apparently normal rectum below the carcinoma while retaining the sphincters rests on the anatomic level of the growth in the bowel. The surgical excision of as wide a segment of the field of lymphatic drainage of the tumor as possible while still preserving the sphincters depends upon the evidence which has been submitted as to the direction of lymphatic spread of these carcinomas.

The direction of lymphatic spread of malignant disease of the rectum has been studied extensively,

and several brilliant demonstrations have been published. These have shown beyond question that the major lymphatic spread of tumors occurring in the upper rectum is upward in the lymphatics accompanying the superior hemorrhoidal vessels. Lesions situated in the midrectum apparently spread not only upward but also laterally in the lymph vessels on the surface of the levator ani muscles to the obturator nodes and ischiorectal fossae. Growths which are low enough to involve the anal canal may, of course, also spread to the lymph glands of the inguinal regions. On the basis of the direction of lymphatic spread, therefore, the carcinomas of the rectum which lend themselves best to consideration of preservation of the sphincters are those situated sufficiently high in the rectum as to be above the level from which lateral spread over the levator ani muscles may occur.

The apparent confusion in the literature as to what level of malignant lesion in the rectum permits of consideration of sphincter preservation undoubtedly stems from our having failed to establish concrete standards of measurement and terminology by which the exact location of a growth could be described so as to be understood with accuracy and consistency by every medical reader. The unfortunate truth is that every surgeon has a different idea of how high in the rectum he can reach with his finger. There even seems to be some difference of opinion as to the actual anatomic length of the rectum, so that what one author describes as "rectosigmoid junction" may be to another "upper rectum" and to a third "lower sigmoid" in level. The recorded distance from the anus of a growth in the rectum will depend upon the position of the patient in which digital rectal and sigmoidoscopic examinations are carried out. This variation in recorded location of the growth in various positions of the patient will, of course, depend on the degree of mobility of the tumor, its gross pathologic type, and also the mobility of the rectal mucosa and the degree of rectal prolapse which may be present.

The relationship of the site of occurrence of the carcinoma on the mucosal surface of a resected portion of rectum, to the level to which there is peritoneal covering on the anterior outer surface of the specimen, has been used, and is equally unreliable and inconsistent as a standard of recording, because the level to which there is serosal covering of the anterior aspect of the rectum is not constant in all patients. In some patients the peritoneum is taut and the pouch of Douglas very shallow, so that lesions which are quite high in the rectum are below the line of peritoneal reflection. On the other hand, in patients with a marked degree of prolapse of the rectum, the bottom of the pelvic cul de sac comes right down to the anal canal. When a total extirpation of the rectum has been carried out, the distance of the growth from the anus can be actually measured on the specimen. But even this measurement is not a constant one, as it will be influenced by the degree of stretching or shrinkage of the specimen.

Hence, undoubtedly, the great discrepancies in opinion in the literature as to what level of carcinoma in the bowel permits of attempts at sphincter preservation are more apparent than real, and much greater unanimity of opinion would be established if a single standard of measurement were selected and used by all. From the practical standpoint, in the preoperative examination of a patient, one suitable fixed basis of measurement would be the distance from the anus of a growth in the rectum as measured on the sigmoidoscope with the patient being examined in the knee-chest position.

Using this standard of measurement, a rule of thumb has been worked out which is a fairly reliable guide in selecting patients who are suitable for operations designed to conserve the anal sphincters. If sigmoidoscopic examination with the patient in the knee-chest position shows the lesion to be a full 6 inches from the anus, then some type of operation which avoids a permanent colostomy is thoroughly justified. On the other hand, if a carcinoma of the rectum is within 4 inches of the anus on sigmoidoscopic examination with the patient in the knee-chest position, no type of operation designed to conserve the sphincters should be even remotely considered if there is any real hope of curing the patient of cancer. To some, this rule may seem somewhat drastic in so far as it is obviously technically possible to resect growths from above which are well within 4 inches of the anus. But it should be remembered that the adoption of the knee-chest position by the patient lengthens his anal canal, slides the rectal mucosa upward, and causes polypoid lesions to hang toward the sigmoid rather than toward the anus. Hence many growths which, on digital rectal examination, with the patient lying on his side, are felt to be only about 2 or 3 inches from the anus, will be found, on sigmoidoscopic examination with the patient in the knee-chest position, to be 5 or even 6 inches above the orifice as actually measured by the scope.

The debatable cases are the borderline ones, in which sigmoidoscopic examination with the patient in the knee-chest position shows the lower border of the carcinoma to be over 4 inches but less than 6 inches from the anus. These are the patients in whom factors other than the actual level of the growth may influence our decision as to whether to attempt sphincter preservation. These other factors are the gross pathologic type and extent of the tumor, the patient's age and general state of health, and the presence or absence of evidence of metastatic spread of the carcinoma having already occurred.

When the growth occurring within the debatable area is small, mobile, and polypoid in type, one is more apt to be conservative in its resection. On the other hand, patients with more advanced, infiltrating, fixed lesions should probably all be subjected to abdominoperineal excision when the tumor occurs anywhere within the terminal 6 inches of the rectum as measured by the sigmoidoscope with the patient in the knee-chest position. The presence of serious

cardiovascular disease, grave renal impairment, or any other condition which is likely to end the patient's life before he has had time to die of his carcinoma will obviously influence the surgeon toward conservatism in debatable cases.

In the very old patient every effort should be made to avoid a permanent colostomy, because cancer in the aged is often very slow growing, and in any event this patient's life expectancy is short. Although younger persons will learn to handle a colostomy so that it is no great disability, the aged individual often cannot do this, and it becomes an open question as to whether it is more important to cure him of his slow growing carcinoma or to relieve him of the intolerable burden of an unmanageable colostomy. Hence, in the very old patient the surgeon may be justified in attempting a resection which permits preservation of the sphincters, if he believes such a procedure has a good chance of ridding the patient of the local lesion permanently, even though such a conservative operation may fall short of the possibilities of cure which would be mandatory in dealing with a younger patient.

The presence of secondary lesions in the liver should not, as a rule, deter the surgeon from making a determined attempt to remove the primary growth. Death from the relatively painless inanition produced by liver metastases is certainly a great improvement over the constant pain and exhaustion resulting from the incessant diarrhea and tenesmus of a persisting primary lesion in the rectum. But when the patient is obviously incurable and the carcinoma is situated at a level in the rectum where it is technically possible to resect it while still preserving the sphincters, such a conservative operation is indicated even though it does not give the patient the best possible chance of avoiding some local recurrence of disease. The metastatic lesions will, in all likelihood, end the patient's life before the local recurrence has become very distressing, and meanwhile he will have been saved the added burden of a colostomy.

The operations which have been devised in the surgical therapy of carcinoma of the rectum range in extent from simple local resection or fulgurization of malignant polypi to the total extirpation of the rectum with its surrounding tissues. Local excision, with or without the increased exposure afforded by splitting the sphincters in the median raphé in the posterior midline, should be reserved for polypi in which the malignant change has not yet extended to the base of the polypus to invade the submucosa. Fulgurization is of value only in dealing with locally malignant polypi or as a palliative procedure in hopelessly inoperable conditions. Radium implantation should be reserved for basal cell carcinomas of the anal canal, because the great majority of adenocarcinomas of the rectum are highly resistant to radiation.

Operations which remove the full circumference of the rectum at the site of the lesion and still preserve the sphincters and permit restoration of continuity of the bowel may be carried out either from above through the abdomen, or from below through the anosacral space, or by a combination of these two approaches. The literature abounds with papers advocating one or another of these methods, describing technical details of the operative procedures, and reporting results obtained. However, a brief description of the technic and summary of the relative merits and disadvantages of each approach may not be out of place in a paper of the general character of this one.

The resection of the rectum from above through the abdomen only, preserving the anal canal below and anastomosing the sigmoid colon to the anal stump to restore continuity of bowel, is often referred to as "anterior resection of the rectum." Actually this operation is the abdominal portion of the complete abdominoperineal excision of the rectum, and the two operations are identical in their extent above the level of the levator ani muscles. In both procedures the ureters are dissected out, the great vessels are left bare, and all the fatty and areolar tissue of the pelvis is removed. The proximal extent of the resection is just as radical in anterior resection with restoration of continuity as in total extirpation, because the descending colon and even the splenic flexure can be mobilized to permit approximation of any part of the colon to the rectal stump without tension. Therefore, the inferior mesenteric artery is tied at just as high a level in this so-called conservative resection as in abdominoperineal excision, and just as extensive a resection of the lymphatic field proximally is thus obtained. The only difference between the two operations is that anterior resection stops short distally at the level of the levator ani muscles, while total extirpation carries on to remove the rest of the rectum and anal canal, most of the levator ani muscles, and almost all of the ischiorectal fat. The advantage of the anterior resection is that, by mobilization of the splenic flexure and descending colon, the upper sigmoid stump can be approximated to the rectal stump below to restore continuity, and thus a permanent colostomy is avoided. Its disadvantage is that it fails to remove the lateral field of lymphatic extension of lesions low enough to spread via the lymphatics on the levator ani muscles. Anterior resection is an excellent operation for carcinomas which are at least 4 inches, and preferably 6 inches, above the anal orifice, as measured on sigmoidoscopic examination of the patient in the knee-chest position. It does not interfere with the nerve supply of the sphincters and the patients all retain full anal control. But it fails to resect the levator ani muscles, and the incidence of local recurrence of disease is high if anterior resection is employed for growths which are really low in the rectum.

Resection of the rectum through the anosacral space without opening the abdomen is frequently spoken of as "posterior resection of the rectum." This approach permits preservation of the sphincters combined with a wide resection of the levator ani muscles, but does not allow as adequate a resection of the lymphatic field proximally as can be

obtained when the abdomen is opened. The descending colon cannot be mobilized, and so the superior hemorrhoidal artery must, of necessity, be tied at a lower level than that at which it is secured when the anterior approach is used. However, posterior resection through the anosacral region does achieve a radical excision of the local lesion with its lateral field of lymphatic spread on the levators, while permitting preservation of the sphincters and restoration of continuity. It is an excellent operation for old people with carcinomas which are too low to be resected by the anterior approach.

The most publicized operation which preserves the sphincter and combines the abdominal and perineal approaches is the so-called "pull-through resection of the rectum." This procedure consists of opening the abdomen to explore the liver and to mobilize the rectum and descending colon. The inferior mesenteric artery is ligated, and the mesentery to the sigmoid and rectum below the site of ligation of the artery is divided. The abdomen is then closed and the patient placed in the lithotomy position. An incision is now made about the anus, which is deepened in the plane between the external sphincters laterally and the rectal wall medially until the anal canal and rectum have been mobilized up to the level to which mobilization was secured from above through the abdomen. The completely mobilized rectum can now be pulled down through the preserved external sphincters until the sigmoid colon, which has a good pulsating blood supply, presents at the orifice. A clamp is then applied and the specimen cut off. The clamp is removed two or three days after operation, and the sigmoid stump is simply allowed to heal to the surrounding margins of the skin. This operation has very few advantages because from the aspect of shock it is no more easy for the patient to tolerate than an abdominoperineal excision of the rectum. Moreover, it is no more radical than anterior resection in so far as little attempt is made to remove levator ani muscles or ischiorectal fat. If ischiorectal fat and levators are extensively resected, then the nerve supply to the retained sphincters is seriously damaged. In any event it is admitted that a certain proportion of patients who have had the pull-through operation never regain full anal continence. It is a technically easier operation than an anterior resection in so far as it avoids an end-to-end anastomosis carried out deep in the pelvis. But what the pull-through gains over anterior resection in technical ease, it sacrifices in certainty of anal continence. The most obvious indication for a pull-through operation would appear to be where a palliative resection is being done on a lesion which is too low to permit anterior resection with restoration of continuity.

No description of the Miles procedure of abdominoperineal excision is necessary, because this operation is still the one most commonly indicated in the surgical therapy of carcinoma of the rectum. Of recent years the newest modification of this classic operation has been the introduction of the two team technic. In this modification two teams work simultaneously, one in the abdomen and the other in the perineum, thus shortening operating time and, moreover, improving the exposure from both aspects in the region of the levator ani muscles. Although this new technic is somewhat dramatic, particularly at the moment when the two teams meet and the specimen is removed, it is doubtful if it has very much to offer over the old classic one team method. With modern supportive measures, the time element in operating has become of secondary importance. Moreover as the two team procedure requires twice as many surgeons, assistants, and nurses, the only people who are actually saving man-hours are the anesthetist and the patient. The frequency with which the rectum is inadvertently opened during the perineal dissection, particularly in cases in which the growth is extensive, low and fixed, and the wide open exposure of the abdominal cavity at the time of this accident when it occurs while the two team procedure is being employed, results in an increased danger of peritonitis and wound infection when this technic is used.

The gist of this paper is that earlier diagnosis of carcinoma of the lower sigmoid colon and rectum will be achieved when rectal bleeding is never simply attributed to hemorrhoids without thorough investigation, and when any change in bowel habit of more than very short duration is taken seriously by all physicians, especially when it occurs in the middle-aged patient. Investigation of a patient with signs or symptoms referable to the left side of the colon or rectum must include repeated tests of stools for blood and sigmoidoscopic examination as well as a careful digital rectal and, frequently, a barium enema x-ray. A fixed standard of measurement of the distance from the anus at which rectal lesions occur is suggested, namely, measurement on the sigmoidoscope with the patient always in the knee-chest position.

Despite all the literature advocating sphincter-preserving operations for carcinomas of the rectum, the total extirpation of the rectum and much of its surrounding tissues by abdominoperineal excision will still be found to be the best procedure in the majority of cases. Attempts at sphincter preservation are not justified when the growth occurs within the terminal 3 to 4 inches of the rectum. If the percentage of long term survivals is to be improved, the patient's chances of being cured of cancer must never be prejudiced by any ill advised attempts to avoid a permanent colostomy. When the patient has a reasonable life expectancy and no evidence of metastatic spread of his carcinoma, an abdominoperineal excision should always be carried out if there is any question at all about the wisdom of attempting a less radical, sphincter-preserving procedure.

The Use of Fluorides in the Prevention of Dental Caries*

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THE prevailing rate of dental caries and resultant tooth loss in the United States is appalling. If the present rate continues to prevail, it is estimated that the average child born today will, when 16 years of age, have required seven dental fillings and two tooth extractions involving the permanent teeth. Furthermore, 40 per cent of those reaching 40 years of age will require dentures. Dental decay is no respector of an individual's age, sex, or economic or social status. The onslaught begins as soon as the child's teeth erupt and continues as long as teeth remain in the mouth.

The physician, being interested in the maintenance of good health, should be just as interested in the prevention of dental caries as he is in the prevention of diphtheria, whooping cough, smallpox, or any other preventable disease.

The early loss of both deciduous and permanent teeth is usually due to dental decay. Premature loss of teeth is one of the major factors causing disturbances of the integrity of the dental arch with resultant malocclusion of teeth. Dental disfigurements, especially when they involve the anterior teeth, may produce undesirable personality changes.

Caries often serve as pathways along which pathogenic organisms advance to produce periapical infections. These foci of infection may be of etiologic significance in septicemia, subacute bacterial endocarditis, arthritis, bursitis, tenosynovitis, or myositis. There is also some data, not as yet of a conclusive evidential nature, to indicate that the carious tooth serves as one of the portals through which the poliomyelitis virus gains entrance to the nervous system.

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Cause of Dental Caries

Most authorities who have studied the mechanisms responsible for the production of dental caries are agreed that caries are caused by the intermittent action of acid, in such a way as to bring about decalcification of the enamel structure of the teeth. glucose and sucrose, with the resultant liberation of lactic acid. The saliva of some individuals contains large amounts of amylase, an enzyme capable of hydrolizing starches in such manner as to produce sugars.

If the lactic acid is not otherwise rapidly neutralized, it becomes neutralized by reacting with the dental enamel, which is principally tribasic calcium phosphate, in such a way as to form calcium lactate. This substance is not nearly as hard as the original enamel substance and is rubbed off the tooth surface in the course of mastication. At a point of repeated acid attack, the enamel becomes thinner and thinner until eventually a microscopic break through the enamel barrier ensues. A combination of action by mouth acid and various putrefactive bacteria then causes further decay of the tooth to progress rapidly.

The degree of harm which mouth acid will produce depends upon whether or not it is neutralized before decalcification of the enamel occurs. This in turn depends upon the rapidity with which acid is formed, as well as the rapidity with which it is neutralized. The rate of acid formation depends upon the number and types of acid-producing bacteria in the mouth, as well as upon the type and concentration of carbohydrates present.

The rate at which acid is neutralized depends upon a number of variables, including (1) the composition, amount, and rate of production of saliva secreted; (2) the shape and occlusion of the teeth; and (3) the extent and firmness of adherence of the bacterial plaque on the teeth.

Method of Control of Dental Caries

In order to better control the incidence of dental caries, (1) the formation of acids in the mouth must be inhibited; or (2) the saliva must be altered so it will neutralize the acids before damage to the enamel can result; or (3) the enamel must be made more resistant to decalcification by mouth acids. Of these three alternatives, the first two are less practical than the third.

Excessive acid formation may be the result of excessive ingestion of carbohydrate or the excessive retention of carbohydrate in the mouth. Each time a fermentable carbohydrate is ingested there is a short but very intensive acid attack upon the

enamel, provided the mouth environment is such that the acid is not rapidly neutralized. Children who consume sugars numerous times daily experience exceptionally frequent and intensive episodes of acid action on their teeth. Very few individuals, particularly children, will voluntarily and regularly restrict their carbohydrate intake to an adequately low level. Even then, proper dietary restriction will not produce significant results in all cases. Some ingested carbohydrate will lodge in inaccessible places and small amounts of sugar will often be as harmful as larger amounts entering the so-called self-cleansing type of mouth.

Theoretically, acid production could also be curtailed through the use of enzyme inhibitors which arrest or slow the activities of the bacterial enzymes acting upon sugars in such a way as to form acids. At the present time there is no known practical method of constantly maintaining an adequate concentration of any enzyme inhibitor in the mouth. There are several dozen enzyme inhibitors, including urea and vitamin K. It is obvious that, to be effective, any such substance must be present in the mouth immediately following the ingestion of carbohydrate. This presents a problem which is difficult to overcome. Very few individuals, especially children, would regularly introduce substances containing enzyme inhibitors into the mouth immediately after consumption of the wide variety of foods and beverages containing carbohydrate.

The capacity of the saliva to neutralize mouth acids can be enhanced by increasing its alkalinity. The *p*H of saliva can be increased by dietary control, a difficult problem to cope with among children. Tooth pastes, particularly those containing dibasic ammonium phosphate, render the mouth secretions more alkaline and are helpful in the prevention of dental decay. Among children, however, it is unlikely that dental paste will be regularly used in such a manner as to reach all parts of all teeth, very quickly after each ingestion of carbohydrate.

Today the most practical method of protecting teeth against decay is to render them more resistant to decalcification by acids. Fluorine, when incorporated into the enamel structure, serves best to minimize such decalcification.

Dental Fluorosis

The first significant description of mottled enamel was reported in 1916 by Black and McKay[1]. The condition is now known as dental fluorosis. Mild degrees of fluorosis are so inconspicuous as to be undetectable except by dentists who are accustomed to looking for its occurrence. Moderate degrees of mottling are manifested as white spots with mild pitting of the enamel, usually noted on the buccal surfaces of the upper anterior teeth. When the fluorosis is more severe, the pitting is more marked and the spots are gray, brown, or black in color. If the fluorosis is very severe, the teeth are malformed and the pitting and discoloration are very extensive.

The possible relationship between the fluoride content of domestic water supplies and dental fluorosis was first suggested in 1931 by Churchill[2]. In 1932 McKay[3] showed that there was a definite and direct relationship between the severity of mottling and the fluoride content of the domestic water supply.

Fluorine-Dental Caries Relationship

There is voluminous literature covering the development of the evidence upon which our current knowledge of the dental caries-fluorine relationship is based. Rather complete reviews of the subject can be found in fairly recent publications.[4, 5] The most significant milestones are deserving of mention.

After it had been demonstrated that objectionable dental fluorosis occurred in areas where the communal water supplies contained from 2.6 to 14.0 parts per million of fluoride, investigations were undertaken to determine what concentration of fluoride constituted a maximum permissible limit. During the period 1933–1937 Dean and his associates[4, 5] conducted extensive studies of the incidence of mottled enamel, in relationship to the fluoride content of the domestic water supply, in a large number of American cities. The results of these studies definitely proved: (1) that with each increase in the proportion of fluoride in the drinking water there occurred, with a precision almost mathematical, a concurrent increase in the extent and degree of dental fluorosis; and (2) that domestic waters containing 1 part per million of fluoride or less were below the mottled enamel threshold. The control of mottled enamel was then the subject of interest. Practically no attention was paid to the incidence of dental caries among children residing in communities where the water supplies contained less than 1 part per million of fluoride. The waters with a low fluoride content were considered to be of no public health significance.

During the 1937–1939 period the studies of Dean and his associates[4, 5] were extended and yielded very significant results. In 1938 it was shown that individuals with mottled enamel were also comparatively free of dental caries. It was also demonstrated that children living in communities where mottled enamel was prevalent showed a relative freedom from dental caries, involving both the deciduous and the permanent teeth, irrespective of whether or not their teeth showed obvious evidence of mottling.

Further investigation was then initiated to determine what concentration of fluoride in a domestic water supply resulted in the maximum degree of protection against caries without producing mottled enamel. These studies were carried out among school children between 12 and 14 years of age living in 21 cities in four states. The results showed the following to be true:

1. When the fluoride content of a domestic water supply is about 1.0 part per million, the dental caries experience is low, and dental fluorosis, to an extent evident to anyone except a trained observer, is prevented.

2. As the concentration of fluoride in the water supply increases above 1.0 part per million, there is little further reduction in the dental caries experience, but the incidence of dental fluorosis, of an aesthetically objectionable degree, increases.

3. As the concentration of fluoride in the water supply decreases below 1.0 part per million, the dental caries experience increases, and below 0.5 part per million it increases very sharply.

These findings have been confirmed by numerous other investigators not only in this country but also in Canada, England, India, and South Africa.

The vast majority of people in Wisconsin consume a domestic water supply containing less than 0.1 part per million of fluoride. Only about 36 communities in this state have a water supply containing 0.5 part per million or more of natural fluoride. Five of them have water supplies containing more than 1.5 parts per million. Only nine have water supplies which naturally contain between 0.7 and 2.5 parts per million.

The benefits which might be expected to result, after the elapse of 12 to 14 years, if the fluoride-free water of a city like Milwaukee were treated so as to raise its fluoride content to about 1.0 part per million have been estimated by Arnold[6] as follows:

1. About six times as many children would have no dental caries experience.
2. The dental caries experience rate would be reduced about 60 per cent.
3. The decrease in the first permanent molar tooth loss would be about 75 per cent.
4. The decrease in dental caries in the four upper incisor teeth would be reduced approximately 93 per cent.

Fluorine Necessary For Optimal Dental Health

The teeth are best protected against the development of dental caries when fluoride is incorporated into the entire thickness of the enamel structure in the form of fluor-apatite. This material is much more resistant to decalcification by mouth acids than is enamel, which calcifies while the daily ingestion of fluoride is inadequate.

The enamel of the first deciduous tooth, which erupts at about 6 months of age, begins to calcify before the sixteenth week of intrauterine life. Calcification of any tooth is believed to continue as long as the tooth remains unerupted. Although fluoride can enter the structure of the enamel as long as the calcification process continues, the most pronounced formation of fluor-apatite occurs during the earlier stages of enamel calcification, the outermost portions of the enamel being formed first.

After the enamel has been fully formed it is without a blood supply and without cellular metabolic activity. Accordingly, ingested fluorides absorbed into the blood stream cannot be incorporated into the structure of the already completely calcified enamel.

McClure[7] has concluded that, exclusive of drinking water, the average daily diet provides from 0.2 to 0.3 mg. of fluorine. In order to best protect dental health, the average child's diet should contain an additional daily supplement of a fluorine equal to about 1.0 mg. of fluorine. McClure[8] has estimated that children in the age group 1 to 12 years, drinking water containing 1.0 part per million of fluorine, will consume from 0.4 to 1.1 mg. of fluorine daily, above that contained in food. This estimated amount of fluoride, needed to supplement that obtained from food, must be ingested during the period of calcification of the dental crown if optimum dental health is to be attained. The crown calcification period continues through the ages 8 to 10, or through the ages 12 to 16 if the third molar teeth are included.

A child will derive the maximum degree of protection against decay of both the deciduous and the permanent teeth if the mother regularly consumes a properly fluoridated water while the child is still in utero and if the child continues to consume such water until approximately 10 years of age. Comparatively little benefit will be derived by an individual who first commences consumption of such water when beyond the age of 8 years.

Deatherage[9] and Klein[10] have presented data indicating that persons whose teeth had already calcified before they began drinking a fluoride-bearing water have experienced some reduction in the caries experience rate.

McKay[11] has presented evidence indicating that the beneficial effects acquired by drinking a fluoride-bearing water during the period of enamel calcification persist into adulthood. These benefits are significant, even in persons over 40 years of age.

Theoretic Objections to Fluoridation

In view of all the available epidemiologic evidence it is entirely logical to assume that the ingestion of water to which fluoride has been artificially added will greatly reduce the incidence of dental caries. There are, however, skeptics who advance two arguments against the desirability of fluoridating domestic supplies without further delay.

The first argument is based upon a theoretic assumption that water artificially treated to raise the fluoride content to 1.0 part per million might not yield the same caries-inhibitory effect, accompanied by the same insignificant amount of fluorosis. Our basic knowledge relating to the behavior of ions and the preliminary reports emanating from such cities as Sheboygan serve to refute this theory.

Fluoridation was begun in Sheboygan on Feb. 25, 1946, following a survey of the dental caries experience of the school children. A resurvey was performed in November 1948. The dental caries experience rate was 19 per cent lower for the permanent teeth and 28 per cent lower for the deciduous teeth zymes which break down various sugars, such as Bacteria such as Lactobacillus acidophilus and mouths of most people. These organisms secrete enafter the fluoridation program had been in operation for only about 32 months. The fluorine, of fluorides dissolved in water, exists in the form of fluorine

ions. These elemental fluorine ions in artificially fluoridated waters are identical with the fluorine ions in natural fluoride waters.

The second argument advanced by skeptics opposed to the fluoridation of public water supplies is that water-soluble fluorides are protoplasmic poisons. They advocate that we await further evidence of the nonexistence of toxic sequelae before recommending fluoridation.

There is no evidence whatsoever that the users of domestic waters containing 1.0 part per million of fluoride have suffered any deleterious effects. Several million people have drunk water, containing from 1.0 to 8.0 parts per million of natural fluoride, from birth to advanced adulthood. With the exception of a significant incidence of dental fluorosis among those who regularly consumed water containing 1.5 parts per million or more of fluoride while the enamel was calcifying, no one has been able to demonstrate that these individuals have suffered any harm. McClure[12] has studied nearly 4,000 high school youths and young adult males who came from communities where the potable water supplies contained from 0.0 to 5.6 parts per million of fluoride. Their height, weight, and fracture experience showed no relationship to fluoride exposure.

The body requires minute amounts of many elements which, when consumed in very large dosage, act as protoplasmic poisons. Iodine, which like fluorine is one of the halogens, is a classic example.

Cost of Fluoridation of Domestic Water Supplies

The cost of fluoridating a public water supply is extremely low in proportion to the benefits received by the water consumers. Sodium fluoride is the chemical which has been generally used where fluoridation programs have already been inaugurated. The cost of the chemical needed to increase the fluorine content of a water devoid of this element, to a concentration of 1.0 part per million is about $2.40 per million gallons. Depending on the amount of water consumption in a particular community, the per capita cost of fluoridation will run from 5 to 15 cents per year.

Investigations are now in progress to determine the feasibility of substituting sodium silicofluoride in place of sodium fluoride. If the use of the former is proved to be practical, the cost of the chemical needed to fluoridate a fluorine-free water to the desired 1.0 part per million concentration will be $0.45 per million gallons. This represents an annual per capita cost of from 1 to 3 cents, depending upon the amount of water consumed in a particular community.

Topical Fluoride Application

It is well established that an initial dental prophylaxis, followed by a series of four topical applications of 2 per cent sodium fluoride solution at intervals of two to seven days, will reduce the incidence of dental decay by about 40 per cent over a period of three to four years. To be most efficacious the first series of applications should be given at age 3 years and the series repeated when the child is 7, 10, and 13 years old.

As a community public health measure, topical application is not an acceptable substitute for fluoridation of the domestic water supply for the following reasons:

1. There is not enough dental manpower to attend to all necessary dental restorative work and also attend to the topical application of fluoride to the teeth of all children at the required periodic intervals.

2. Topical application is less effective in reducing dental caries experience. The reduction is about 40 per cent for a period of three or four years following a single series of applications. The expected reduction among those regularly consuming a properly fluoridated water from birth until 12 to 14 years of age is about 60 per cent.

3. There is evidence to show that the beneficial effects derived from drinking a fluoride-bearing water during the period of enamel calcification persist into adulthood. There is no evidence to indicate that the protective effect derived from fluoride applied topically during childhood does likewise. There is data[13] which suggests that fluoride applied topically to the teeth of adults offers little or no protection against the development of caries.

4. The cost of a single series of four topical applications is greater than the per capita cost of fluoridation of a domestic water supply over the course of the average individual's entire lifetime.

5. A fluoridated water supply benefits all of the people, irrespective of their social or economic status, without effort on their part. Only a comparatively small percentage of the population will receive the benefits of topical application. Lack of interest, procrastination, and cost will all serve as deterrents.

Topical application of fluoride is, however, the best dental caries preventive measure now available for use where people are without a communal water supply. It is also to be recommended for children living in communities where fluoridation of the domestic water supply has not been inaugurated.

Support For Fluoridation of Domestic Water Supplies by Medical Profession

A large number of people in a greater number of communities in Wisconsin are now regularly consuming an artifically fluoridated domestic water supply than in any other state in the union. The Wisconsin State Dental Society on March 19, 1945, by unanimous action of its House of Delegates, recommended the fluoridation of public water supplies deficient in fluoride content.

The Fluorine Study Committee of the Wisconsin State Dental Society is composed of dentists who have individually and collectively promoted the fluoridation of communal water supplies in all parts of the state. The physicians of every community should join forces with their dental colleagues and convince

the people, and their local elected representatives, that any public water supply which does not contain about 1.0 part per million of fluoride is not a truly potable one. Only when such action is taken will each and every local community in the state, which now has a water supply deficient in fluoride, inaugurate a fluoridation program at the earliest possible date.

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INTERNATIONAL COLLEGE OF SURGEONS ANNOUNCES DATES OF ASSEMBLY

The International College of Surgeons, United States Chapter, will hold its fifteenth Annual Assembly and Convocation in Cleveland, Ohio, October 31–November 3, 1950. Dr. George M. Curtis of Columbus, Ohio, is chairman of the assembly.

The program will include scientific sessions on subjects in the fields of general surgery; eye, ear, nose, and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic, and neurologic surgery. In addition, an extensive technical and scientific exhibit will be presented. Special entertainment has been planned for the doctors' wives.

According to an announcement by Dr. Arnold S. Jackson, Madison, Wisconsin, secretary of the United States Chapter, several hundred surgeons will be received as associates and fellows of the college at a convocation to be held in the Cleveland Public Auditorium on November 3.

All doctors of medicine who are interested in surgery and its advancement are invited to attend and can obtain a program upon request to Dr. Arnold S. Jackson, Secretary, United States Chapter, International College of Surgeons, Jackson Clinic, Madison 4, Wisconsin. For hotel reservations, doctors should contact the Committee on Hotels, International College of Surgeons, United States Chapter, 511 Terminal Building, Cleveland 13, Ohio.

STATE EXAMINERS IN BASIC SCIENCES SCHEDULE EXAMINATIONS

The next two examinations of the Wisconsin State Board of Examiners in the Basic Sciences will be held as follows:

September 30, 1950: 8 a. m. to 5 p. m. at The Assembly Chamber, State Capitol, Madison, Wisconsin. The last filing date is September 23, 1950.

December 2, 1950: 8 a. m. to 5 p. m. at the Plankinton House, Milwaukee, Wisconsin. The last filing date is November 25, 1950.

THE MEDICAL FORUM

DOCTORS PREPARE MEDICAL CIVIL DEFENSE SYSTEM

Doctors Meet to Push Prepaid Health Plans

Chicago, June 5.—The first two of a series of regional conferences on voluntary health insurance have been held at Forth Worth, Texas, and Raleigh, North Carolina.

The conferences are sponsored by the Council on Medical Service of the American Medical Association in an effort to increase enrollment in voluntary systems, develop "catastrophic coverage," expand individual enrollment programs and to step up promotional and sales activity on the part of accident and health insurance companies and the Blue Cross–Blue Shield plans in 1950.

In a letter supporting the conferences, Whitaker and Baxter, who direct the National Education Campaign of the AMA, declared:

"This is our year to make the entire country 'health insurance conscious'—and to prove that education, rather than legislation, is the proper approach to the problem."

County Societies and Hospitals Line Up Emergency Programs

E. L. HENDERSON

Dr. Elmer L. Henderson, Louisville, Ky., was inaugurated as president of the AMA at a specially broadcast ceremony from San Francisco on June 27.

Madison, July 5.—Wisconsin is well ahead of most other states in its preparations for rendering emergency medical and hospital service in the event of a "hot" war in the United States, declared Dr. Frank L. Weston, chairman of the State Medical Society's Committee on Military Medical Service.

For almost 2 years the committee has been developing civil defense and disaster plans involving medical personnel. Other members of the committee are Drs. M. J. Musser, Madison; J. S. Wier, Fond du Lac; J. M. Sullivan, Milwaukee and A. H. Gundersen, La Crosse. Dr. Weston reported that 31 out of the 52 county medical societies in the State of Wisconsin have operating committees for providing medical care in event of an emergency.

At a meeting on July 5, the State Medical Society committee completed detailed plans for the organization of "disaster units" in every county of the state. Plans of the State Medical Society will be integrated with plans already established in many cities of the state, including Milwaukee, Ashland and Eau Claire.

The medical society is working in close cooperation with the Wisconsin National Guard and the Adjutant General's Office, the Red Cross, the State Board of Health and members of other health professions. Under the program established by the State Medical Society, disaster units in each county will be available to handle emergency situations in the field.

The units include a collection team to go immediately to the scene of the disaster and screen the casualties, a first aid team to render immediate emergency care, an ambulance team to transport casualties to local field or general hospitals, surgical and medical teams and a supply section to mobilize all available medical supplies in the area.

Reorganization Plan No. 27 May Pass; Ewing Pressures Senators

BULLETIN: The House killed Reorganization Plan No. 27 by a vote of 249 to 71.

Washington, D. C., June 15.—President Truman's latest reorganization plan (No. 27) transforming the Federal Security Agency into a Department of Health, Education and Security, stands an excellent chance of running the Congressional gauntlet successfully, according to Gerald G. Gross, editor of the Washington Report on the Medical Sciences.

He says opposition will be more difficult than it was last summer when the AMA spearheaded a drive which brought defeat to a similar plan (Reorganization Plan No. 1):

1. **The White House claims to have removed the major objections raised to the plan.**
2. **The President and Oscar Ewing have taken both Republicans and Democrats into confidence in drafting the new plan.**
3. **It must be defeated by a vote in either the Senate or House before July 31 or go into effect automatically. The crowded Congressional calendar makes it likely that it will go by default unless pressure is brought on Congress.**

Dr. Joseph S. Lawrence, director of the AMA Washington office, reports that Plan No. 27 does not carry out the Hoover report recommendations for a full time agency devoted to health and it does not require a physician to be secretary, as urged by the AMA.

FSA "Survey" Says Voluntary Insurance Can't Do the Job

Says Plans Paid Only 10% of Nation's Health Bill

Madison, May 11.—The Federal Security Agency under the administration of Oscar R. Ewing has issued a study purporting to show that "in 1948 voluntary insurance met only a small fraction of the costs of illness in the United States."

The article published in the January-February 1950 issue of the Social Security Bulletin concludes that voluntary insurance met no more than 10 to 11 per cent of all income loss and physicians and hospital services expenses in 1948.

According to the report, employees suffered a minimum loss of $4.1 billion income due to nonindustrial illness and injury in 1948.

The privately financed medical bill of the nation was estimated at $7.4 billion. This included services of physicians, hospitals, dentists, nurses, miscellaneous healing arts, medicines and appliances, student fees for medical care and administrative and net costs of voluntary insurance (see Table 1).

Table 1.—Private Expenditures for Medical Care in 1948 (in millions)

Item	Amount
Physicians' services	$2,141
Hospital services	1,864
Dentists' services	864
Nurses' services	200
Medicine and appliances	1,807
Misc. healing professions	273
Administrative and other net costs of voluntary insurance	270
Student fees for medical care	3
Total	$7,422

It was said that the people spent $2.1 billion for physicians' services and $1.8 billion for hospital services—a total of $4.0 billion in 1948.

Ewing's survey states that commercial accident and health insurance policies earned premiums of $914 million for income-loss indemnity and for hospital, medical and surgical expenses. Not more than 52 per cent of this ($473 million) was paid back in benefits, according to the survey. Commercial group policies, the report says, pay benefits equal to about 78 cents of the average premium dollar, while commercial individual policies pay about 38 cents on every premium dollar (see Table 2).

Table 2.—Premium and Benefit Payments Through Commercial Insurance Against Sickness Costs in 1948 (in millions)

Type of policy and insurance	Premiums earned	Losses incurred (benefits)
All policies, total	$914	$473
Income loss	493	245
Hosp., med., and surgical	421	228
Group policies	391	273
Income loss	179	125
Hosp., med., and surgical	212	148
Individual policies	523	200
Income loss	314	120
Hosp., med., and surgical	209	80

So-called non-profit voluntary insurance plans were reported to have earned about $454 million in premiums in 1948 and paid out about $377 million in benefits, so that persons covered by these plans received an average of about 83 cents per dollar of premium payment (see Table 3).

Table 3.—Income and Benefit Payments Through Voluntary Non-profit Insurance Against Costs of Hospital and Medical Care in 1948 (in millions)

Type of insurance plan	Earned income	Benefit Payments
Total	$454	$377
Blue Cross and Blue Shield	365	307
Other Hosp. and Med. care plans	9	6
Consumer sponsored	33	27
Industrial plans	25	19
Bituminous coal industry plans	12	9
Private group clinics	7	6
Student fees for med. services	3	3

After going on at some length to explain that generous "allowances" were made for possible under-reporting or failure to include some benefits, the survey concludes that even "with these arbitrary increases it is improbable that the final estimates in any way understate the value of sickness benefit payments through voluntary insurance."

In summary, the report states that voluntary insurance of all types (see Table 4) in 1948 did not cover more than 7 per cent of current income loss; no more than 9 per cent of the total consumers' medical care bill; and no more than 16 per cent of the total physicians' and hospital service bills.

Table 4.—Income Loss, Private Expenditures for Medical Care, and Offsetting Voluntary Insurance Payments Through Insurance Companies and Non-profit Plans in 1948

Losses and Expenditures	Income Loss and/or Medical Care Expenditures (in billions)	Percent met by voluntary insurance benefits
Income loss only	$ 4.1	6.0– 6.7
Total medical care costs	7.4	8.2– 8.8
Income loss plus total medical care costs	11.5	7.4– 8.0
Physicians and hospital services only	4.0	15.1–16.3
Income loss plus Physicians and hospital services only	8.1	10.5–11.4
Income loss with 1-week waiting period, plus cost of physicians, hospitals, dentists, and nurses, plus 1/3 cost of drugs and appliances, plus net cost of insurance	8.6	9.9–10.8

AMA Membership to Include Journal

San Francisco, June 28.—The House of Delegates of the AMA voted unanimously to set the 1951 dues at $25. Included in the dues is a subscription to the AMA Journal. Fellows will pay an additional $2, and will have a choice of either the AMA Journal or an AMA specialty journal.

State Papers Support "Rededication Month"

Madison, June 15.—The newspapers of Wisconsin, both weekly and daily, are participating in giving wide publicity to "Rededication Month" as a means of renewing the people's faith in the ideals of liberty and justice upon which the Nation is founded.

C. W. Brown, editor of the Oconomowoc Enterprise and Will Conrad, editor of the Medford Star-News are co-chairmen of the event for Wisconsin. Governor Oscar Rennebohm recently issued a proclamation designating June as "Rededication Month", as did the governors of all other states.

Outagamie County Society Urges Full-Time Public Health Unit

Appleton, April 15.—The Outagamie County Medical Society has recommended that the county board appoint a health council to study the feasibility of a full time Outagamie County Health Unit which, under ideal conditions, would replace all health departments in the county, including those in cities, villages and school systems.

Because the plan is a radical departure from the present system, Dr. Walter S. Giffin, secretary of the county society, said that the society feels a county-wide committee composed of doctors, dentists and laymen should be appointed to conduct a thorough study of all the implications of the proposed program, the cost and the potential savings to taxpayers.

He added that the proposal has been discussed at a number of medical society meetings where doctors agreed the plan should be studied by others in addition to physicians.

Dr. J. L. Benton, Dr. Lester Haentschel, Dr. Marvin Kagen, Appleton; Dr. George L. Boyd, Kaukauna; and Dr. John Russo, Little Chute, compose the medical society committee which has been making preliminary studies on the setup.

Doctor Benton said several counties of Wisconsin already have replaced disjointed health systems with county departments and that the city of Green Bay has consolidated all of its health services under one head.

The physicians pointed out that public health work as it functions now in the county is not satisfactory to many groups. The city of Appleton has no nurse at all. It was only recently that the county department became fully staffed.

Doctor Benton said the state board of health considers the ideal setup for a county of Outagamie's size the employment of a physician trained in public health work as a full time public health officer; a supervisor of nurses and 14 public health nurses, one sanitary engineer, one veterinarian who would take care of milk and meat inspection, etc., a health educator, a nutritionist and 4 clerical workers.

Interest Grows in Health Council Idea

Madison, May 8.—Public interest is growing in the necessity for county health councils, according to Miss Gertrude Clouse, Secretary of the Wisconsin Public Health Council.

In a recent bulletin to members of the Wisconsin Public Health Council she pointed out that the Polk County Public Health Council held its first annual meeting at Balsam Lake on March 13 this year. The president was quoted as saying:

"No annual report can possibly measure enthusiasm. If it could, this report from committee chairmen would show that many persons have spent a great deal of time thinking seriously about, and working hard toward effective means of achieving better public health.

"If difficulties have been encountered this first year—and they most assuredly have—it is because pioneers have never had it very soft!"

Keen interest is being evidenced in Barron County which has already established a health council, and in Washington, Green, Manitowoc, Outagamie, Menomonie Falls and Portage Counties.

Blow-up Over Hospital Economy in Armed Forces

Washington, D. C., May 8.—A virtual explosion has followed the Defense Department's order closing several military hospitals and other facilities of the Armed Forces in a move to effect economy.

The House Armed Services Subcomittee which investigated military hospital cutbacks has asked Defense Secretary Johnson to again review the conflicting arguments over his order.

After open hearings in Washington and two inspection trips the committee was faced with two sets of testimony, so far apart factually that no recommendations could be made.

AMA Opposes H.R. 5182; Medical Unification Bill

Madison, April 15.—The American Medical Association has joined the American Legion, Veterans of Foreign Wars and other veterans groups in opposition to H.R. 5182, the bill aimed at consolidating all federal medical activities into a United Medical Administration.

Sacrifice Quality

The AMA reported that it could find no evidence of how H.R. 5182 would accomplish the economies recommended by the Hoover Commission "without sacrifice of the quality of service rendered and without interfering with the special missions of certain of these services."

AVOID THE CATASTROPHE LOSS!

We are all concerned about being disabled or hospitalized for an extended period of time. Time coverages are designed to help with the minor losses, and to assume the major burden of the catastrophe loss.

Our new Hospital-Surgical plan is the only real answer to the tremendous expense of an extended hospital confinement:

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No Hope in Socialized Medicine, McPherrin Tells State Audiences

Madison, June 13.—There is no hope, no peace of mind or real security in the concept that "the state is my shepherd, I shall not want," was the message given by John W. McPherrin, editor of the American Druggist, New York, N. Y., as he spoke to nearly 2,000 people in Wisconsin on a recent three meeting tour.

Controls Inevitable

Under the sponsorships of the State Medical Society and the local doctors, druggists, dentists and businessmen, Mr. McPherrin spoke to more than 350 persons at a public meeting in La Crosse, to more than 100 professional men at Wausau, and to more than 1,300 members of the Wisconsin Federation of Women's Clubs attending their annual convention in Wausau on June 13.

"I am convinced," said McPherrin, "that if we Americans were to adopt the Truman health program, which is, for all practical purposes, the same as the British health scheme, we would have to accept the same kind of controls." That is his conclusion after a five-week tour of England in which he studied the British health scheme.

Complicated Regulations

"Each new problem uncovered by the operation of a comprehensive national health scheme seems to create a need for new controls. It has been found also that each compromise with private enterprise seems to complicate the whole operation."

"Government Is Master"

He said that Aneurin Bevan, British health minister, told him that "the only way socialized medicine can work in any country is under complete government control. The minister must be the master."

McPherrin said that such a policy "has done something to the British spirit and to their faith in themselves. If this country ever accepts a similar plan, be prepared to accept increased government controls and higher taxation."

Supernaw Named to AMA Vet Committee

San Francisco, June 27.—A 5-point program for improving medical care for veterans and closer cooperation between the U. S. Veterans Administration and the medical profession was proposed by Dr. J. S. Supernaw, Madison, at the 99th annual convention of the American Medical Association.

Dr. Supernaw was named chairman of the AMA's Corelating Committee on Medical Care of Veterans at the convention.

Urges Medical Agencies

During the meeting the AMA House of Delegates approved a resolution introduced at Dr. Supernaw's request, urging that all state medical societies establish veterans medical service agencies to deal with the Veterans Administration. Wisconsin has had such an agency since 1947.

Study G. I. Trainees

In addition, Dr. Supernaw urged a study to coordinate veterans hospital construction with that of general civilian hospitals, improve pension examination work by physicians on behalf of veterans, simplify administrative procedures of the VA and determine what can be done about veterans who have taken medical training in foreign medical colleges and now find that they cannot be licensed to practice in this country.

The AMA also considered a plan to provide needy veterans with non-service connected disabilities with medical, surgical and hospital care through voluntary health insurance contracts supplied by the VA.

Wisconsin Has 39 Blood Banks in 27 Cities

The AMA has just completed a blood survey revealing that Wisconsin has 39 blood banks of all types in 27 cities. There are 1,636 blood banks and centers in the United States. They are located in 951 cities. The banks issue 3.5 million pints of blood yearly.

AMA READIES AD CAMPAIGN

Begin Ads in October

Chicago, June 12.—The final "go ahead" signal for a nationwide advertising campaign including newspapers, magazines and radio has been given by the American Medical Association as a new phase of the national education campaign against socialized medicine and for voluntary health insurance.

Clem Whitaker and Leone Baxter announced that the ad campaign will be launched in October with a total budget of $1,110,000—newspapers, $560,000; radio, $3,000,000, and magazines, $250,000.

The schedule calls for blanket coverage of every bona fide daily and weekly newspaper in America—nearly 11,000—with 70 inches of space being run during the week of October 8th.

About 30 of the leading national magazines, and a score of advertising trade publications, will be included in the ad program.

An intensive "spot announcement" campaign will be conducted on some 300 radio stations.

The ad copy will be designed to sell voluntary health insurance, but not any particular brand or plan. It will also urge support of a basic American ideal—the principle of individual freedom as opposed to the alien philosophy of a government-controlled economy.

A new series of thirteen four-minute radio talks are now available in radio and script form for broadcast under the sponsorship of local county medical societies or as an educational or public service feature.

The series brings home to every cross section of American life just what is at stake in the trend toward socialism and, specifically, the threat in the administration's proposal for compulsory health insurance.

This series is available from the State Medical Society office in Madison, and can be used effectively as a regularly scheduled thirteen-week program. The transcribed talks run approximately four minutes with a live open and close to be read by the station announcer, identifying the program with the Medical Society.

GEORGIA ADOPTS WISCONSIN PLAN IDEA: OTHER STATES EXPAND PREPAID PLANS

The Richmond County Medical Society approved a new comprehensive medical insurance service-type plan for city employes in Staten Island, N.Y., who earn up to $5,000 per year. Employes have completely free choice of physician. The plan is underwritten by Group Health Insurance, Inc., a member of Cooperative Health Federation of America.

* * *

Nearly 36,000,000 people in U.S. and Canada were enrolled in Blue Cross at the end of 1949. Net gain in membership for the year was over 3,000,000. Twenty-three per cent of the U.S. population is enrolled.

* * *

More than $327,000,000 was paid to hospitals by Blue Cross plans for the care of 4,500,000 Blue Cross members in 1949. This total represented 84 per cent of Blue Cross plan income.

* * *

The California Medical Association voted by an overwhelming majority on May 2 to increase premium rates by 25 per cent for all persons now obtaining health coverage through California Physicians Service. The recommendation will go to the CPS board of trustees for final approval.

* * *

A "package plan" of welfare benefits is bieng offered experimentally by California Physicians Service to meet labor union-employer demands. It includes a standard surgical contract, two-visit deductible medical coverage and extended hospital benefits; life and accident insurance, total disability insurance and unemployment compensation disability. A well-known private insurance company will underwrite all except the medical, surgical and hospital benefits.

* * *

The Medical Association of Georgia is sponsoring a new prepaid nonoccupational surgical plan (Georgia Surgical Plan) which will be sold by private insurance carriers. It is an adaptation of the Wisconsin Plan originated by the State Medical Society of Wisconsin.

* * *

Blue Shield coverage of people in South Carolina began on April 1, 1950, according to the South Carolina Medical Assocaition.

Two Networks Broadcast AMA Inaugural Speech

San Francisco, June 27.—Two national radio networks—Mutual and American Broadcasting Company—broadcast the actual inauguration of the new president of the American Medical Association, Dr. Elmer L. Henderson, Louisville, Kentucky.

The half-hour inauguration ceremony was broadcast at 6 p. m., Tuesday, June 27, from the grand ballroom of the Palace Hotel during a meeting of the House of Delegates. Millions of listeners all over the country heard brief addresses by Dr. Louis H. Bauer, Hempstead, New York, chairman of the board of trustees; Dr. Ernest E. Irons, Chicago, the retiring president; and Dr. Henderson.

Health Co-ops Set Up Medical Scholarships

St. Paul, May 31.—Members of health cooperatives in Minnesota have started plans for a scholarship fund which will help to provide training for personnel needed in cooperative health plans.

The fund was approved at a recent meeting of delegates of the Group Health Association.

The program calls for voluntary contributions from 400 local health groups, based on ten cents per member, with matching contributions from Group Health.

Local AAUW Units May Oppose Federal Medicine

National Gives Go Ahead

Madison, June 20.—Local units of the American Association of University Women (AAUW) have the permission of the national organization to pass resolutions opposing socialized medicine, according to Kathryn McHale, general director of the AAUW.

Recently, state and local units of the AAUW have declined to pass such resolutions on the ground that it was not AAUW policy.

In a letter to the Woman's Auxiliary of the American Medical Association, dated May 2, 1950, Director McHale said:

"The legislative program of the American Association of University Women is voted at its biennial convention and no branch may oppose any principle supported by the convention. Where the Association takes no position on a subject, however, branches are free to take any stand they like. It is assumed of course that any branch will make it clear that it is acting in its own behalf and expressing its own views and not the views of the national association."

Press Works to Stop Industrial Accidents

Madison, June 9.—A substantial reduction in industrial accidents is the goal of a nation-wide newspaper advertising and news campaign which has the endorsement and support of the Wisconsin Press Association, according to Carl Zielke, Madison, business manager.

The campaign got under way following a conference on June 5.

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References furnished on request.

British Doctor Defends National Health Plan in Letter to New England Medical Journal

(The correspondence below was printed in The New England Journal of Medicine, March 16, 1950.)

TO THE EDITOR: We read that the American medical profession and indeed Americans generally are interested in the National Health Service of Great Britain. The fight of the American physicians against "socialized medicine" is likewise a matter of constant comment in professional circles here. I have followed these matters in your columns and elsewhere for some time—though trained in Canada, I have practiced there and have also worked under the N. H. S. in this country. May I take the liberty of trying to express a point of view that reflects this dual background of experience? I am not an apologist for the N. H. S., and politically I belong to neither the extreme Right nor the Left. I have no personal interest whatever in American developments, and I must ask you to excuse a perhaps too-critical note in my remarks.

Shortages Cause Trouble

Space forbids a lengthy discussion of the N. H. S. I would only say that it is in its infancy, and is undergoing the trials and tribulations peculiar to that period of life. Abuses have occurred, and treatment standards, especially in the matter of delays in hospital admission, leave much to be desired. Many, if not most, of the dissatisfactions with the N. H. S. on the part of the public are directly attributable to a shortage of skilled staff, especially nurses, and to a general shortage of hospital accommodation, which is the result, in large measure, of the war and its aftermath. From the point of view of the profession, the dissatisfactions have chiefly arisen because of the intransigent attitude of the Ministry of Health in the various points at issue. This is a reflection of the personality of the Minister, and I have little doubt that Mr. Bevan enjoys his present position largely because he was willing and able to deal with the doctors in a manner calculated to nullify the obstructionist attitude of a large section of the profession.

Claims Resolution "Untrue"

It is, nonetheless, flatly untrue to state that "WHEREAS the experience of all nations where government has assumed control of medical services has shown that there has been . . . a progressive deterioration of medical standards and medical care to the detriment of the people . . ." a resolution that was recently passed by the New Hampshire Medical Society. Presumably, Great Britain was included in this reference, and available statistics fail to bear that contention out.

In the various specialist branches, the very keen competition at each stage of the ascending scale of hospital appointments that eventually lead to full consultant status ensures that the standards are maintained. Indeed, one of the results of the N. H. S. has been a general increase in the salaries paid to junior hospital staffs; financial need has thus been greatly reduced as a deterrent to specialization, and for this reason among others specialist standards are, if anything, rising. True it is that the role of the general practitioner has not yet been stabilized under the N. H. S. There has been a diminution of his responsibility, and the fear has arisen that general practice may become the haven of the disappointed would-be specialist. But is not the American profession, largely as a result of increased specialization, faced with much the same problem?

Voluntary Plans Abused

I have practiced in Canada under a voluntary prepaid scheme providing medical care, and can safely say that abuses were just as frequent as under the N. H. S. This scheme was entirely under the control of the medical profession, and yet needless operations were performed, and superfluous visits made and charged against the scheme. A voluntary scheme administered by the profession does not provide a ready-made answer; the problem of abuses still remains. It is clear that doctors are, if not as other men, at least subject to a degree to their weaknesses.

Can any intelligent view of today's world doubt that the debate between the advocates of complete *laissez faire* and state control is out of date? The problem is how to exercise democratic control; "free enterprise" as understood by John D. Rockefeller has surely been dead since the days of William Jennings Bryan. The truth is that political forces over which the medical profession has no control will demand that financial barriers to adequate medical care be swept away. Citizens will, by and large, tend to vote for the politicians who promise medical care at Government expense; in the current British election, no party has promised to abolish the N. H. S. It does not meet the case to point with pride to the excellent service available to "public" patients; in the final analysis, these are at least in part charitable, and some stigma attaches to their use. In any case, the needs of the medically indigent lower-middle-income group are not met. And no voluntary prepaid scheme will answer, precisely because those who most need care will not voluntarily sacrifice present income to future hypothetical needs. No doubt this is unfortunate, but it is one of the facts with which politicians have to reckon.

Politics in Medicine

In the face of this, the evidence that the American profession is becoming a high-powered political pressure group causes dismay in at least one of your readers. In the process, the spokesmen for medicine seem, at times, to indulge in the same rather meaningless claptrap as other politicians. It seems senseless to link "socialized medicine" with communism, as has been done in your columns; one might as well attack compulsory state-controlled education as a factor undermining the "American way of life."

M.D.s Can't Defy Government

British experience indicates that the medical profession is not strong enough to defy a government that, theoretically at least, has the support of the majority of voters. This proposition appears to be self-evident. In its present stand the American profession, or at least that section of it which supports the American Medical Association levy, is gravely prejudicing its future position. Future events may show that these present-day activities are paving the way for an American Bevan, who will be reflexly conditioned to oppose any suggestion, however, reasonable, advanced by the leaders of the profession.

Thank you for any attention you may give this letter.

DOUGLAS FINDLAY, M. D.
Leyton, London, E. 10

NOTE: The proponents of voluntary health insurance and the professionally guided extension of essential medical care to all are not advocates of complete *laissez faire*. It may be hoped that there are few such advocates to be counted in the ranks of the medical profession. Were the opponents on any controversial issue always able to view both sides of the argument dispassionately, there would be less controversy and more discussion and compromise.—Ed.

The Louisiana and Virginia state legislatures have sent resolutions to the U. S. Congress requesting that it not enact a compulsory health insurance system for the nation. A total of fifteen states have now taken this action.

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A special house lobbying committee has asked 166 business corporations to supply specific and comprehensive data on direct or indirect lobbying activities. No professional organizations or associations have been included in this request.

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The White House has indicated that it wants to expand the present limited U.S. employe health plans in more cities and governmental centers. Increased benefits will be considered later. This development is significant because nearly 2,000,000 persons work for the federal government in non-military jobs.

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Less than two weeks after the South Amboy, N. J., explosion, the Federal Security Agency processed and approved security claims with a total value of over $100,000 filed by 59 survivors of 31 workers who were killed in the disaster. The first monthly benefit checks, ranging from $35 to $85, were mailed on June 5 covering the month of May.

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The scheduled dismissal of 4,700 VA medical personnel has been cancelled by Congressional action approving an additional appropriation of $2,000,000 to continue their employment for the remainder of the fiscal year.

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The AMA Washington office will again be expanded, upon recommendation of the House of Delegates of the American Medical Association, which met in San Francisco, June 25–30.

This will permit the office to give better service to physicians and improve contacts with legislators.

ANA Wants Nursing in Prepaid Plans

Won't Oppose Socialized Plan

Madison, June 15.—A large per cent of the nation's nurses went on record May 9 as wanting their services included in prepaid medical and hospital plans whether such plans are voluntary or compulsory.

The American Nurses Association house of delegates, acting for 171,000 nurses, voted twice on the issue.

One vote carried a resolution requesting "The American Medical Association and other recognized national professional and health organizations to work jointly with the ANA for the inclusion of adequate nursing service in voluntary, nonprofit prepayment plans."

The second vote approved the ANA 1950–52 platform which calls for the promotion of nursing "in prepaid health and medical care plans."

An effort to have the word "voluntary" included in the platform plank failed, and the nurses left themselves free to work for and nurse in whatever plan comes before the public.

"5-Percenters" May Run Medicine, Dewey Says

Albany, New York, May 18.—"If Washington should ever get control of the health and medical research of this country, nobody would ever know whether the federal wholesale purchase of drugs for the masses of our people was determined by doctors or by the five percenters," declared Governor Thomas E. Dewey at the dedication of the Sterling–Winthrop Research Institute in Albany.

He said that the voluntary insurance plans are marching steadily forward, and in one instance, nearly 85 per cent of the people in the city of Rochester enjoy the protection of voluntary health insurance plans.

"What has been done in Rochester can be done in the nation. This maximum of protection against all kinds of medical needs can be accomplished by a free people in the free American tradition and without government taxation or compulsion, and without enslaving the doctors or ruining our standards of care."

Taft Condemns Truman Reorganization Plan

Washington, June 9.—Senator Robert A. Taft has condemned President Truman's Reorganization Plan No. 27 to create a Department of Health, Education and Security as a program of Oscar Ewing's to turn his administration into a government department and to make himself a Cabinet member.

Reorganization Plan No. 27 is almost exactly like Reorganization Plan No. 1, which was defeated by the Senate last year.

"It seems to me," said Senator Taft, "that the plan has all the objections which the plan had last year; and, therefore, I should think under the same circumstances it is likely to be defeated primarily because it does not conform to the Hoover Plan, and, I may say, apparently because Oscar Ewing just would turn the Federal Security Administration into a government department and in turn make Oscar Ewing, instead of a Federal Security Administrator, a secretary in the Cabinet."

He continued. "There is a good deal of resentment in Congress about that, too, which is likely to raise more political objection, perhaps, to the plans than the one based entirely on logic."

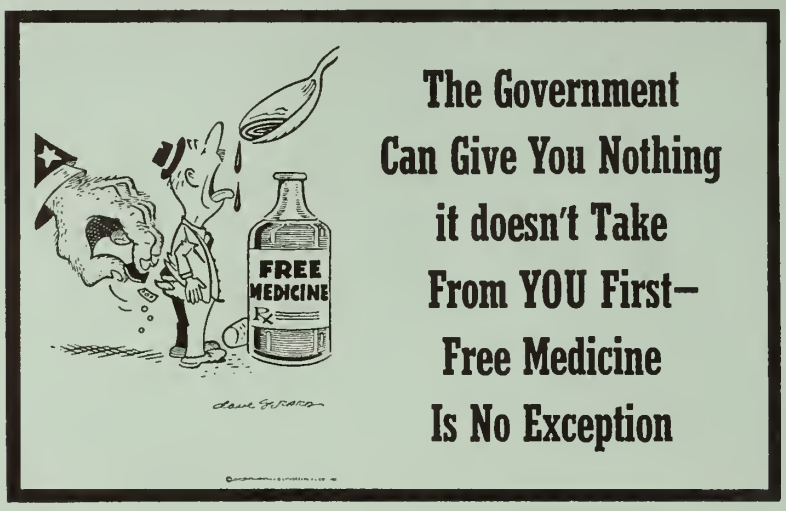
He said that the big issue is that welfare people, "like Oscar Ewing, want to run health as a kind of welfare service. The doctors and others feel that medical care and health is a special subject, which ought to be dealt with by people expert in the health field and not subject to welfare directions."

Dr. Lull Recommends Good Reading for M.D.s

Chicago, June 5.—For the doctor who likes to relax with a good book, Dr. George F. Lull, secretary and general manager of the American Medical Association, suggests two volumes written by physicians.

One is authored by Dr. Seale Harris of Birmingham, who has written an excellent biography of J. Marion Sims, entitled "Woman's Surgeon." Dr. Sims is known as the father of modern gynecology in this country.

The other book, entitled "Saw-Ge-Mah," (Medicine Man), a novel concerning the life of a contemporary physician, was written by Dr. Louis J. Gariepy of Detroit.



Is There Room in the Poorhouse for 149 Million People?

In 1932, Franklin D. Roosevelt, then a presidential candidate, had this to say about government spending:

"Any government, like any family, can for a year spend a little more than it earns. But you and I know that a continuance of that habit means the poorhouse."

Those words, important seventeen years ago, have even greater significance today. Why? Because in every year since 1932 (with the exception of the two fiscal years immediately following the war) our *Federal government has spent more than it has collected!*

Surely the time has come to make our present administration realize that a government which continually spends more than it collects cannot long remain strong and healthy.

In 1932, our Federal government spent 4½ billion dollars. For the fiscal year of 1950, it is estimated that our Federal government will spend *ten times that amount* . . . 45 billion dollars.

To give you an idea of just how much money this is, consider these facts:

1. If everyone in the United States cashed in all of his life insurance policies, the total would amount to 44 billion dollars. This would not be enough money to run the government for one year.

2. About 11 million urban families own the homes they occupy, valued at 30 billion dollars. If converted into cash, this amount would run the government for only 8 months.

3. About 3,900,000 farmers farm their own land, valued at 17 billion dollars. Besides this, they own tools and livestock valued at 8 billion dollars. If converted into cash, the total of 25 billion dollars would run our government for less than 7 months.

4. If every manufacturing concern converted its net working capital into cash, the total would amount to 39 billion dollars. That's hardly enough to run the government for 11 months.

These facts put a new light on the staggering size of our Federal government's planned 45-billion-dollar expenditure for the fiscal year of 1950. And remember, this excessive spending is in the face of a national debt of more than 250 billion dollars!

Isn't it as true today, as it was in 1932, that "a continuance of that habit means the poorhouse"?

Just what are *you* doing to end excessive spending by our Federal government? Have you written your Senators? Have you discussed the problem with your business associates . . . with other businessmen . . . with your friends . . . with your employees?

Let's make sure our representatives in government know how we at home feel about the continuance of a habit that "means the poorhouse."

The time for action is NOW!

More Hospital Patients Than Ever Before

Chicago, May 6.—More people were admitted to U. S. hospitals in 1949 than ever before in history, reports the Council on Medical Education and Hospitals of the AMA in its yearly review of hospital service.

Nearly 16,660,000 patients were admitted in 1949, a total which does not include hospital births numbering 2,800,000.

The report shows that there are 1,937 government hospitals with 1,025,155 beds and 4,635 nongovernmental hospitals with a total of 413,875 beds.

Doctors Inefficient

(Balsam Lake Ledger, Feb. 9, 1950)

Gust A. Isaacson, town of Lincoln farmer who made a trip to his native Sweden last year, implies in a recent article written about his trip that some of the doctors in Sweden have a tendency to be inefficient under socialized medicine.

He says: "You pay for doctor and hospitalization whether you need it or not and doctors who are paid by the state are much like union laborers, more money and less work. With socialized medicine, what do the doctors care if you are not satisfied with them. If you don't come back that means less work for them. Still, most of the doctors are very conscientious."

Mr. Isaacson goes on to cite the case of his sister in Sweden who went to two doctors who found nothing wrong with her. Finally a third doctor ordered her to a hospital, where three successive operations were necessary for her.

Sweden is a welfare state, says Mr. Isaacson, and opines: "If all the social benefits are for the best, opinions differ a great deal. One thing is certain, money must be collected directly and indirectly and IT DOESN'T COME LIKE MANNA FROM HEAVEN."

The caps in the last paragraph are ours. We just wanted to emphasize that even in a welfare state everyone is a taxpayer. You never get more than you pay for.

Vertigo*

Differential Diagnosis and Treatment

By JOHN R. LINDSAY, M. D.
Chicago

J. R. LINDSAY

Doctor Lindsay, a member of the American Academy of Ophthalmology and Otolaryngology, the American Laryngological, Rhinological, and Otological Society, and the American Otological Society, is professor of otolaryngology at the University of Chicago School of Medicine and associated hospitals. He obtained his M.D. degree from McGill University Faculty of Medicine, Montreal, in 1925, and took special postgraduate training in Canada and abroad.

THE symptom of vertigo is extremely common in medical practice. The terms "vertigo," "dizziness," "giddiness," and "light-headedness" are all in common use and more or less interchangeable. Such a complaint may arise from a variety of conditions, most common of which are diseases of the inner ear, certain ocular disorders, and diseases of the central nervous system and the vascular system, and may sometimes have a psychogenic basis.

The otologist is primarily interested in vertigo which takes origin from the vestibular portion of the inner ear or its central connections. This type of vertigo is usually a definite sensation of movement, either of the environment or of the subject, usually rotatory but sometimes linear. It is accompanied by nystagmus and ataxia and, in severe cases, nausea and vomiting. Vertigo which arises from the ear can usually be distinguished quite readily from the dizziness or sense of confusion of ocular origin.

The name of Mèniére has become closely associated with attacks of vertigo of aural origin. Terms which are in common use are Mèniére's syndrome, or symptom complex, Mèniére's disease and pseudo-Mèniére's syndrome.

The term "Mèniére's disease" has been given to a specific condition which was originally described by Mèniére[1], consisting essentially in recurring attacks of vertigo associated with hearing impairment and tinnitus of a fluctuating type. While Mèniére did not know the underlying pathologic changes of the inner ear in this condition, it was the good fortune of Hallpike and Cairns[2] in 1938 to be able to examine the inner ears of 2 patients with this disease and to discover the type of pathologic lesion in the inner ear. An increasing number of histologic examinations since then (Yamakawa[3], Rollin[4], Lindsay[5], Altmann and Fowler[6], Lindsay and Day[7], Cawthorne[8]) have born out the fact that Mèniére's disease is based upon an inner ear condition known as hydrops of the labyrinth of the idiopathic type.

Mèniére's syndrome or symptom complex is a name which has become rather loosely attached in recent years to any attack of vertigo and deafness or tinnitus that could not be definitely attributed to labyrinthitis, tumor, or traumatic injury. Mèniére's syndrome when used in this connection is, therefore, not a diagnosis, since it includes at least several types of conditions of the inner ear.

In general medical practice, attacks of vertigo occur more frequently without any associated auditory disturbances and without any definite disease of the central nervous system. Vertigo of this type frequently cannot be localized definitely to either the central or the peripheral vestibular apparatus. The general term "pseudo-Mèniére's syndrome" has been frequently applied to this type of attack of vertigo.

Classification

In considering vertigo of aural origin, it is convenient from the standpoint of localization to divide it into three general groups: (1) vertigo which is a symptom of a known disease of the central nervous system; (2) vertigo of the type generally classed as pseudo-Mèniére's syndrome, in which localization may be indefinite; (3) vertigo which is peripheral in origin, which includes the inner ear and eighth nerve.

Vertigo Arising from Diseases of the Central Nervous System.—Vertigo is a common symptom in such diseases as brain tumor, brain abscess, or other inflammations, concussions, vascular accidents, chronic degenerative diseases such as multiple sclerosis and syringomyelia, and intoxications by certain drugs, and as an accompaniment of migraine. More rarely, vertigo has been observed to precede a convulsive seizure or simulate such a seizure in that the sudden vertigo of a few minutes' duration may be followed by drowsiness and sleep for several hours.

In tumor of the posterior cranial fossa, vertigo has been found to occur in as high as 90 per cent of cases. It is more common in diseases of the central nervous system to have a postural type of vertigo rather than a vertigo which is continuous. A postural vertigo is one which may not be present in the upright position but which makes its appearance or becomes aggravated by a change in position or

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

by the assumption of certain definite positions of the head. In such diseases, while the history and otologic examination may contribute valuable information, the establishment of the diagnosis usually depends upon the presence of other symptoms and signs of disease of the central nervous system.

Pseudo-Ménière's Syndrome.—In otologic practice the majority of patients who come with the complaint of vertigo having conditions falling into the class of so-called pseudo-Ménière's syndrome. That is, they suffer sometimes from vertigo in the form of attacks but more frequently a postural vertigo without auditory disturbances and without other evidence of disease of the central nervous system. Some of the conditions which are known to give rise to this type of vertigo may be listed as follows:

1. Toxic Disturbances: Infection and Drugs: Infections of the upper respiratory tract, probably of a virus origin, and sometimes acute sinus infections, may give rise to vertigo which is usually of the postural type.

Intestinal infections may also cause the same symptoms.

Certain infectious diseases have a tendency to cause vertigo without auditory disturbances.

Certain drugs may produce the same symptom; examples are barbiturates, alcohol, morphine, paraminobenzoic acid, streptomycin, and many others. In most of these cases the tests of vestibular function may be normal and recovery is complete. In the case of streptomycin there is a severe loss of vestibular excitability. It is probable that vertigo of this type takes origin in the central nervous system, although positive information may be lacking.

2. Hypotensive State: Individuals with an abnormally low blood pressure, low basal metabolic rate, and sometimes signs of vasomotor instability sometimes have vertigo in the form of an attack but more commonly a postural type. The attacks may be recurrent or may never reoccur. No permanent loss of function is usually produced, and vestibular tests usually give normal results.

3. Vasomoter Disturbances: A common example of this group is the vertigo which often occurs at the climacteric. This is usually a postural type of vertigo, but it may have a sudden onset. Recovery is spontaneous, but attacks may recur for a few years.

Hypertension and Arteriosclerosis: It is a common occurrence in these conditions to have a vertigo in the form of attacks without auditory disturbances. Such attacks usually clear up spontaneously after a few weeks, without any loss of function or loss of excitability of the vestibular apparatus. The most probable explanation would seem to be on the basis of occlusion of a minute vessel due to arteriosclerosis. A central origin seems most probable but is not definite.

5. In addition to the above fairly distinct groups there are many cases of vertigo of this type in which no etiologic factor can be discovered. The vertigo may be severe at the onset but usually becomes postural and may persist anywhere from a few days to several years. The eventual prognosis is good.

Treatment and Prognosis: The treatment of pseudo-Ménière's syndrome depends upon the causation. The usual treatments which are given for Mèniére's disease are not indicated. The first essential is to rule out the possibility of progressive disease of either the central nervous system or the inner ear. A careful history and hearing tests are necessary to rule out an early Ménière's disease, bearing in mind that this disease occasionally produces vertigo as its first symptom and deafness only after a few months. If such progressive diseases can be excluded, the prognosis for vertigo of this type is always good.

Vertigo Arising from the Peripheral Ear or Eighth Nerve.—The chief indication for a peripheral origin of vertigo is the association with deafness or tinnitus or both. While it is possible for vertigo to have a peripheral origin without associated auditory phenomena, it is usually not possible to make a definite diagnosis. The common causes of vertigo of peripheral origin are as follows:

1. Labyrinthitis: Diffuse or Circumscribed: Labyrinthitis usually occurs secondary to middle ear infection, less frequently as an extension of leptomeningitis, and in rare cases as an hematogenous spread of infection. The management of labyrinthitis is discussed in all textbooks on otology.

2. Fistula Symptom: A spontaneous fistula in the bony labyrinth capsule is most common in cases of cholesteatoma but occurs in congenital syphilis and other granulomas, occasionally in tumors of the temporal bone, and in rare cases may result from pressure over the carotid sheath. The symptom arises from erosion of the bony portion of a semicircular canal, creating a soft spot, which then allows movement to take place of the fluid within the bony canal with each increase or decrease in middle ear pressure. This may occur with or without an intact tympanic membrane. The fistula test is easily done by means of a Politzer bag and a tightly fitting tip in the external auditory canal. Positive and negative pressure can each be applied with such an arrangement. Pressure with the finger over the external meatus may bring out the vertigo and nystagmus in cases of active fistula. The creation of an artificial fistula is the basis of the fenestration operation for improvement in hearing in selected cases of otosclerosis.

3. Tumor: Temporal Bone, Eighth Nerve and Cerebellopontine Angle: Tumors of the temporal bone, such as carcinoma, may erode the bony capsule of the labyrinth and cause vertigo with or without a positive fistula symptom.

Acoustic neurinomas usually begin with tinnitus and loss of hearing in one ear. Vertigo occurs occasionally in attacks, but more often as a postural symptom. Tests for vestibular excitability usually show a profound loss of response in the affected ear. X-rays of the internal auditory meati may show dilatation on the affected side. Other signs in the central nervous system, such as loss of the corneal reflex, may be recognizable early.

Other tumors involving the cerebellopontine angle may also cause inner ear deafness and destroy vestibular function. The rapidly progressive loss of response to vestibular tests along with advanced deafness of the inner ear is an important indication of tumor.

4. Fractures of the Temporal Bone: The most common type of temporal bone fracture is the longitudinal fracture, which occurs more or less parallel to the long axis of the pyramid and extends from the parietal bone down through the mastoid and external auditory canal wall in its upper posterior aspect, causing tearing of the drum in that region. There is usually bleeding from the ear and sometimes loss of cerebrospinal fluid. Such patients have a conduction deafness as a general rule but may also have a high tone nerve deafness due to concussion.

A less common type of temporal bone fracture is the transverse fracture, which goes through the pyramid transversely, usually through the vestibule. There may be no bleeding from the ear; function is profoundly impaired or completely destroyed. Facial paralysis is common. Such a fracture occurs from the more severe head injuries; therefore, few survive.

In addition, there are frequently combinations of the two types of temporal bone fracture. The diagnosis of fracture is usually established by x-ray examination. The presence of the longitudinal fracture can often be determined on local examination of the bony external canal where the fracture line persists permanently.

5. Concussion of the Ear: The hearing loss produced by a blow to the head in the region of the ear which has not been of sufficient severity to cause a fracture may vary all the way from a mild dip at the 4000 frequency to a profound inner ear deafness. The blows of a mallet, as during mastoidectomy when the mallet and gouge are used, may cause a permanent loss of hearing at the region of the 4000 frequency. In mild conditions there may not be any vestibular disturbance, but the more severe concussion of the ear carries with it vertigo and impairment of vestibular function. The nature of the inner ear lesion remains in doubt. A direct injury to the neural elements may be responsible for the interference with function; however, hemorrhage is known to occur in the inner ear fluids in such cases and must also be considered a possible cause of loss of function. The degree of recovery varies greatly. Considerable improvement in function commonly takes place, but in some cases there is an apparent progressive deterioration of the hearing for weeks or months after the initial injury. The onset of the deafness in concussion cases may be immediate, or it may occur gradually over a period of hours after the injury. The accompanying vertigo varies in severity, and vestibular responses are impaired also to a varying degree.

6. Allergy: Many cases have been reported in which vertigo, deafness, and tinnitus have accompanied an acute allergic attack involving the upper respiratory tract. It is apparently possible for an allergic upset to affect the inner ear directly. More common perhaps is the middle ear impairment due to eustachian tube blockage as a part of the allergic reaction. Inner ear deafness as a true effect of topical allergy is apparently not common. The theory has been proposed that Ménière's disease or hydrops of the labyrinth is the result of a physical, or intrinsic allergy affecting the internal ear.

7. Toxic Neuritis or Neurolabyrinthitis: The eighth nerve and especially the peripheral cochlear neurone are known to be susceptible to a variety of toxic influences. Many infections as well as many drugs have a tendency to affect the eighth nerve.

Mumps. A typical example of what is believed to be a toxic neuritis due to infection is the hearing loss which frequently follows mumps. The usual course is the onset of tinnitus, impaired hearing, and sometimes a mild vertigo at about the time the acute parotitis is subsiding. Investigation of the hearing, using appropriate masking, shows that hearing is rapidly and permanently destroyed. Vestibular responses, however, are not destroyed, but remain active to a normal degree. Involvement is practically always unilateral. A histologic examination of such ears has not been so far carried out.

Acute Infectious Diseases. Some other infectious diseases, for example, typhus, have a tendency to affect the eighth nerve and produce a hearing impairment of the inner ear, sometimes also vertigo. The hearing loss in some cases is reversible. Clinically, it would appear that some viruses affecting the upper respiratory tract may cause a rapid and complete loss of hearing in one ear, somewhat similar to that which occurs with mumps. If the vestibular function remains active, the interpretation is that the hearing loss was of a toxic nature.

Ramsey-Hunt Syndrome. Another example of toxic neuritis is deafness and vertigo which occasionally accompany the so-called Ramsey-Hunt syndrome, consisting of herpes oticus, facial palsy, pain in the side of the head, and sometimes vertigo, tinnitus, and deafness.

Uveitis, Nonluetic Interstitial Keratitis, Parotitis, and Labyrinthitis. There are also rare cases in which profound deafness, usually bilateral, accompanies an ocular disturbance and sometimes chronic parotitis. The nature of these infections is undetermined. Some type of a virus seems most probable. In such cases there is usually vertigo and some loss of vestibular function but to a considerably less degree than the loss of hearing. Prognosis for hearing improvement is usually poor.

8. Vascular Accident: Vascular accident in the inner ear has been commonly referred to in medical literature as the basis for Mèniére's syndrome or disease. Mèniére, in his original description of the disease, which is now called after him, did not attribute the condition to a vascular accident. He did, however, report a case, which has become famous, in which there was a hemorrhagic exudate into the inner ear, but he did not connect it with the clinical

entity now known as Mèniére's disease. The present day interpretation is that this case was probably one of leukemia in its late stages, since patients with leukemia may occasionally have a sudden disturbance of the inner ear in the terminal stages. Examination of such ears has revealed a fibrinous type of exudate in the perilymphatic spaces thought to be mainly due to hemorrhage.

Because of this finding in late leukemia, the diagnosis of "hemorrhage in the labyrinth" has frequently been made in cases of sudden deafness in adults past middle age.

The syndrome, which might reasonably be attributed to a vascular accident in the inner ear, either a hemorrhage, thrombus, or vascular spasm, would have a sudden onset in a previously healthy ear, with severe tinnitus, deafness, and vertigo, with permanent impairment of function of varying degree. Both vestibular and auditory function might be destroyed. The cases that would seem to fit the diagnosis of a vascular accident are relatively rare.

9. Sudden Deafness of Undeterminate Inner Ear Origin: Sudden deafness in a previously healthy ear along with dizziness has been not uncommon in patients mainly between the age of 20 and 45. The usual story is a sudden onset of tinnitus and deafness of varying severity in a previously healthy ear. There is a permanent hearing loss of the inner ear type which affects high tones more than the low tones. The hearing loss varies all the way from a relatively mild impairment of the high tones to a profound deafness of the inner ear. Patients with a mild impairment of hearing may experience no vertigo. When the hearing impairment is moderate to severe, there is usually vertigo with nausea and vomiting. After the acute stage of the vertigo has passed, such patients may exhibit a reduced response to caloric tests and may have a definite postural vertigo which is constant for as long as three to four years. The vertigo appears only in certain positions, which they learn to avoid. In very severe conditions there may be a subtotal loss of vestibular response as well as of the hearing. The causation in these cases is obscure. If the patient is in the forties, the tendency has been to diagnose a vascular accident, but this diagnosis does not fit patients who are in the early twenties. Because the onset has sometimes coincided with a head cold or some other known infection, some type of toxic neuritis seems a likely explanation, but the permanent impairment of vestibular function, as well as the postural vertigo which occurs in proportion to the hearing loss, does not correspond to a toxic neuritis such as seen in mumps, in which the vestibular function remains normal although the hearing is destroyed. Histopathologic examination of such ears is so far lacking, and the exact causation and pathologic changes remain in doubt.

10. Mèniére's Disease or Hydrops of the Labyrinth: This diagnosis can only be made in the case of the following syndrome: recurrent attacks of vertigo, of the vestibular type, associated with tinnitus and deafness of a fluctuating type in which low tones are primarily involved and bone conduction reduced along with air conduction. The diagnosis of Mèniére's disease cannot be made in the presence of vertigo attacks without auditory disturbances, although in occasional cases the onset of the disease is marked by dizzy spells for a short time previous to the onset of auditory symptoms.

The hearing disturbance in Mèniére's disease is characteristic to such an extent that a low tone deafness of the inner ear, in which the threshold fluctuates widely and in which there is an intermitent diplacusis or unusually disagreeable sensation with loud sounds, can sometimes be diagnosed as due to hydrops of the labyrinth in the absence of vertigo. The histologic examinations of a sufficient number of ears have now been made to establish the basic condition as hydrops or dilatation of the endolymphatic fluid system. The etiologic agent of the hydrops is so far indefinite; however, the theory that the condition is the result of a physical or intrinsic allergy seems at present to have some basis. While the hearing loss for low tones and tinnitus are the most constant characteristics of Mèniére's disease, the attacks of vertigo are usually the most distressing to the patient. These attacks are usually unpredictable in frequency, duration, and severity. In early cases caloric responses of the labyrinth may be within the normal range; in advanced conditions there is likely to be some impairment. The acute attack may be accompanied for a short time by postural vertigo; more often the attacks are of sudden onset and subside fairly quickly. In about 10 per cent of such cases the second ear may be affected at any time within four or five years after the first.

Treatment: Treatment of Mèniére's disease may be divided into medical and surgical.

Medical Treatment. Medical treatments may be divided into several groups. One group is based on the elimination of salt and the use of mild diuretics in order to keep down the fluid content of the tissues. Such treatment would seem to have some rational basis in view of the hydrops, which is the basic pathologic lesion. Furstenberg, Lashmet, and Lathrop[9] recommend a sodium-free diet along with ammonium chloride in large doses, 6 to 8 Gm. per day, for alternating three day periods. The treatment would be kept up for about six weeks. Talbott and Brown[10] instituted the use of a low salt diet and potassium chloride up to 8 Gm. per day in divided doses. They attributed the benefit partly to removal of fluids and partly to the effect upon the conductivity of the nerve impulses. In the author's hands the most satisfactory treatment has been the use of a low salt diet along with potassium chloride. The latter has been given in a liquid form, 2 teaspoonfuls of a 25 per cent solution morning and evening during the meal. Along with this, careful attention should be paid to general supervision of the patient's activities. The intake of food and fluids should be equally distributed in the three daily

meals. Regular rest is necessary. Barbiturates may be given when necessary for sleep, and the patient's physical and mental activities should be limited to some extent. There appears to be some relationship between the expenditure of mental energy and the activity of the disease. Much benefit is frequently gained by cutting down the number of working hours per day and by careful adherence to a regular routine in all the patient's habits.

Other treatments which have been popular are injections of histamine, as instituted by Horton[11] and his associates, and the use of nicotinic acid. In recent reports Horton has recommended that intravenous injections of histamine be given over periods for as long as four to six weeks. For details of the treatment the reader should consult the reports by Horton and his associates.

Nicotinic acid has also been recommended on the hypothesis that in certain cases Mèniére's disease is the outcome of a vascular constriction in the labyrinth. The use of nicotinic acid developed from the discovery of its use in pellagra. Selfridge[12] reported beneficial results in cases of nerve deafness, and Harris and Moore[13] later reported favorable effects on Mèniére's disease of nicotinic acid and thiamine chloride combined. Atkinson[14] has since recommended its use in patients not sensitive to histamine as determined by skin tests.

The recent development of drugs which have a favorable effect in preventing motion sickness has prompted their use in Mèniére's disease, Mèniére's syndrome, and pseudosyndrome. The results obtained with dramamine have seemed to indicate that it is of definite value in aural vertigo which is of moderate or mild degree.

In addition to these treatments there have been many others in use from time to time. The use of inflation of the eustachian tubes has been recommended, but in the hands of most people has given no help in the majority of cases. There is no reason to attribute the hydrops of the labyrinth to an occlusion of the eustachian tube.

No form of medical management has been universally effective, but sufficient improvement can usually be expected so that surgical treatment does not need to be considered in more than 10 to 15 per cent.

Surgical Treatment. Surgical treatment may be divided into two groups, firstly, intracranial section of the eighth nerve or the vestibular portion of the eighth nerve, and secondly, labyrinthine operation.

Intracranial Nerve Section

Intracranial section of the vestibular part of the eighth nerve, according to MacKenzie and Dandy, has been successful in stopping attacks of vertigo, but has not consistently stopped the tinnitus. It has a disadvantage of the risk of an intracranial surgical procedure, but is otherwise a suitable procedure in those cases in which it is desirable to preserve the hearing. The operation does not affect the hydrops directly and could not be expected to stop the tinnitus or the progressive loss of hearing which is characteristic of the disease. While it has the advantage of being able to preserve hearing when carried out by expert hands, it carries the usual risk of intracranial surgical procedure. Patients with a profound loss of hearing and with severe tinnitus would appear to be more suitable for labyrinthine operation, which carries less risk.

Labyrinthine Surgery

Several types of labyrinthine surgical procedures have been practiced.

Portmann's operation[17] consists in opening the saccus endolymphaticus without otherwise opening the labyrinth. This operation has the advantage of preserving the hearing. It has not been universally successful, however. This has undoubtedly been due to the fact that when the saccus is opened or torn or destroyed it heals over promptly. This has been demonstrated in animals by the author[18]. Any therapeutic effect could be only temporary.

Alcohol Injection.—Injection of alcohol into the labyrinth has been extensively used, principally in England. This has been carried out both through the footplate of the stapes and through an artificial fistula in the horizontal semicircular canal. The method destroys both auditory and vestibular function. Results have been reported as good but not invariably successful. Tinnitus has remained in some cases.

Fenestration.—A simple fenestration of the labyrinth without destroying the membranous canal has been tried but has not given any reliable benefit.

Coagulation of the Labyrinth.—Coagulation of the membranous labyrinth through a fistula in the horizontal canal near its ampulla has been proposed and carried out by Day[19]. The coagulation as used by him has consisted of a relatively weak current with the coagulating tip extending through the ampulla of the horizontal canal barely into the vestibule. Day has preserved hearing in approximately 10 per cent of his cases.

Ablation of Horizontal Canal Ampulla.—Cawthorne[20] has used ablation of the ampullary end of the horizontal canal through an artificial fistula as his method of choice. He has reported consistent relief of vertigo but always total loss of hearing.

Lempert[21] describes an operation which consists primarily of opening the vestibule and cochlea in severe cases of Mèniére's disease in order to destroy hearing and tinnitus along with prevention of vertigo.

At the present time there is no operation on the labyrinth which can be expected to prevent attacks of vertigo and at the same time consistently preserve hearing. While Day's coagulation procedure has preserved hearing in about 10 per cent of his cases, the same procedure in other hands has always caused total deafness in that ear. From a clinical standpoint some sort of labyrinthine surgical treatment offers a definite advantage because of simplicity and safety from the operation. In cases of severe hearing loss and severe tinnitus, it is often desirable

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to destroy the auditory apparatus with the vestibular apparatus. In cases of bilateral disease, however, labyrinthine operation is rarely suitable. In cases in which the hearing in the affected ear is still reasonably good, labyrinthine operation has the objection of sacrificing the hearing. This loss must be balanced against the additional operative risk of intracranial operation for section of the eighth nerve.

Interruption of Sympathetic Nerve Supply.—Removal of the stellate ganglion, division of preganglionic fibers of thoracic 1 and 2, and stripping and cutting of the vertebral artery on the side of the affected ear have been carried out by Passee and Seymour[22] in a number of cases. This was done on the hypothesis that the etiologic factor in Mèniére's disease is one of vasoconstriction and that it could be relieved therefore by interruption of the sympathetic nerve supply. The report on the first 12 cases has been good. If proved successful, the method will have the advantage of preserving auditory function in the affected ear.

Summary

When confronted with the complaint of vertigo, dizziness, or lightheadedness, the essential steps in the procedure to be followed might be outlined as follows:

1. To differentiate between dizziness of the aural or vestibular type from the type of uncertainty or loss of balance that may come from such causes as ocular disturbance, syncope, psychic reaction, etc.

2. To differentiate between one of the three main groups described above: *(a)* disease of the central nervous system; *(b)* disease of the peripheral vestibular system; or *(c)* pseudo-Mèniére's syndrome or the group in which there may not be sufficient proof to indicate a definite point of origin.

3. Having determined to which group the case belongs, the differential diagnosis can then be considered. The treatment and prognosis depend upon the diagnosis.

4. The differential diagnosis and treatment in the case of pseudo-Mèniére's syndrome and in the case of vertigo which arises definitely from the inner ear or eighth nerve, peripheral to the brain stem has been discussed.

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The Coagulation Mechanism*

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THE study of the coagulation of the blood, especially in relation to hemorrhagic diseases and intravascular clotting, has attracted the attention of the medical profession since 1666, when Malpighi discovered that clotting was due to the separation of a mass of fibers from the blood. In 1904 Morawitz presented an explanation of coagulation, which is commonly designated as the classic theory. It is epitomized by the two equations:

Prothrombin + thromboplastin + Ca^{++} = thrombin

Fibrinogen + thrombin = fibrin.

This theory served as a reliable guide for nearly half a century. It furnished the basis for the development of a simple method to determine prothrombin, and it supplied a satisfactory explanation for the bleeding diathesis due to lack of vitamin K, which was discovered in 1934.

In recent years it became apparent that the classic theory was not adequate and that further progress could be made only by the formulation of a new hypothesis which correlated the important findings made during the past few years. Such a hypothesis was made in 1947 and later expanded to incorporate a series of important discoveries.

The hypothesis is summarized in the diagram in the next column.

The two major factors in this scheme are the platelets and thrombin. For coagulation to occur, platelets must disintegrate in order to liberate the enzyme which converts thromboplastinogen to thromboplastin. The latter agent immediately reacts with a group of compounds, which collectively constitute

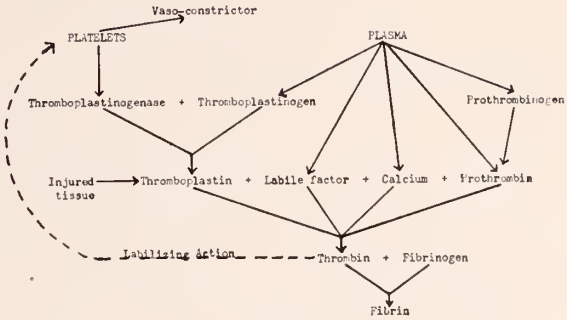

Chart 1

the prothrombin complex, to form thrombin. Not only does thrombin react with fibrinogen to form fibrin, but it acts on the platelets, making them unstable, so that their disintegration speed is increased. Thus more platelets rupture, more thromboplastin is formed, and the production of thrombin is markedly accelerated. This gives rise to a chain reaction which is responsible for the increasing speed of the clotting reaction. The reactions that bring about the production of thrombin can be designated as the "thrombinogenic cycle."

Any factor that reduces the production of thrombin or removes it too rapidly will break the cycle and produce a hemorrhagic diathesis. One of the basic reasons why a break in the thrombinogenic cycle causes defective hemostasis is the retardation of platelet lysis, with its concomitant decrease in the liberation of the platelet-vasoconstricting agent. Significantly, fibrin itself is the most important remover of thrombin. It is the fibrin clot which retards and moderates the formation of thrombin and the resulting lysis of platelets. This insures a slow but sustained liberation of the vasoconstricting agent, thereby furnishing essential conditions for effective hemostasis. Heparin with its plasma co-factor is such a powerful neutralizer of thrombin that it stops coagulation and platelet lysis completely. Rarely, however, is heparin found in the blood.

The common hemorrhagic diseases can be divided into two general classes: the hypothromboplastinemias and the hypoprothrombinemias. In the first class belong thrombocytopenic purpura and hemophilia. In the latter disease, the thromboplastinogen is deficient. A rare clinical entity resembling hemophilia, and therefore often called hemophilia-like disease, has been found to be caused by an inhibitor of the platelet enzyme.

The hypoprothrombinemias can be divided into the congenital and acquired. The hypoprothrombinemias due to vitamin K deficiency or liver injury and those which occur after the administration of drugs such as dicumarol are the most common types. The recent discovery that prothrombin exists partly

* Presented before the One Hundred Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

in an active form and partly in a precursor state has introduced another element into the coagulation mechanism which must be evaluated.

While the basic concept of hemostasis has become more comprehensive and complicated, the clinical approach has actually been simplified. By means of two tests, the prothrombin time and the prothrombin consumption time, a diagnosis can usually be made with certainty. A low prothrombin activity as measured by the one stage prothrombin procedure immediately establishes a defect in the prothrombin complex. The prothrombin consumption test, which is based on determination of the amount of prothrombin left in serum after coagulation is completed, measures the available thromboplastin of the blood. In thrombocytopenia and in hemophilia little prothrombin is consumed. After adding normal blood to hemophilic blood either by transfusion or in a test tube, the prothrombin consumption is definitely increased. This constitutes at present the most reliable means for evaluating therapy in this disease. This test promises to furnish the means for the isolation from normal blood the active substance which is lacking in hemophilic blood, just as the one stage prothrombin test furnished the assay method for isolating from the spoiled sweet clover hay the toxic principle now known as dicumarol.

Summary

A new hypothesis of coagulation of the blood is offered in which the platelets and thrombin are the major factors. By means of this concept the coagulation defects can be divided into the hypothromboplastinemias and hypoprothrombinemias, and this becomes the basis of a rational classification of the hemorrhagic diseases. The prothrombin time test and the prothrombin consumption test are the most reliable diagnostic means.

BUREAU FOR HANDICAPPED CHILDREN ANNOUNCES DATES OF ORTHOPEDIC FIELD CLINICS

The Bureau for Handicapped Children of the State Department of Public Instruction recently announced the dates for the orthopedic field clinics to be held during the last half of 1950. The clinics are conducted by the Division for Crippled Children for persons under 21 years of age who come within the state's definition of a crippled child.

It is preferred that referrals be made by the family physician, but when this is not feasible, arrangements may be made by writing directly to the Bureau. Unless otherwise directed, forms for referral may be obtained from the Bureau and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons to be examined, so that the required personnel may be made available. Families who return the signed form will be notified of their hour of appointment a few days before the clinic.

Parents and physicians are invited to attend the clinic with the child. If the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau is interested in knowing of this in advance.

The cities and dates are as follows:

Lancaster	July 6–7
Ashland	August 10–11
Wausau	August 24–25
Manitowoc	September 7–8
Marinette	September 13
Kenosha	September 19–20
Superior	September 22
Green Bay	September 28–29
Racine	October 12–13
La Crosse	October 17–20
Sheboygan	October 26–27
Chippewa Falls	November 9–10
Eau Claire	November 16–17
Appleton	November 23–24
Fond du Lac	December 7–8

Correspondence concerning the clinics should be addressed to the Bureau for Handicapped Children, 146 North, Capitol, Madison 2, Wisconsin.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
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More Information on Air and Motion Sickness

On this page (October 1949, p. 930) we briefly discussed Dramamine and its usefulness in motion sickness, but recently other pertinent information has become available which adds to our knowledge of this drug and its spreading field of usefulness which appears to justify this additional comment.

McEvedy[1] (1949) belatedly reported that in 1947 he had noticed that patients in a ship's hospital who were being treated for allergy with antihistaminic drugs were strikingly free from seasickness. As a consequence he began administering antihistaminics to those reporting for this complaint. On comparing scopolamine to the antihistaminics, he considered the latter to be nothing less than equal to the former.

Chinn and Oberst[2] report that Benadryl and Dramamine are identical in activity, since the 8-chloro-theophylline does not add to or significantly modify the action of the Benadryl component. "Hyoscine," or scopolamine, has been used for some years combined with some form of barbiturate for the treatment or prevention of motion sickness, and now these authors give the drug scopolamine along with Benadryl and thus combine the depressant action of scopolamine with the antihistaminic action of Benadryl and feel that they obtain better results with the combination than with either drug used alone.

Although some writers may have grave doubts as to the efficacy of Dramamine or its active constituent, Benadryl, in the symptom complex often termed motion sickness, evidence is accumulating that a significant action occurs in a goodly percentage of individuals tested. Campbell[3] has presented evidence that seems to be at least very significant and pertinent. In the fenestration operation, in cases of otosclerosis, it is well known that vertigo and nausea are very frequent and disturbing. In a series of 28 patients, individuals given Dramamine, 8 were markedly, 8 considerably, and 9 moderately relieved. In 8, discontinuance of the drug was followed by recurrence of symptoms, to be relieved again on receiving the drug; on the whole, those patients receiving Dramamine were significantly less disturbed than the controls. These observations seem to justify the belief that the drug does have a relieving action in instances in which nausea and vomiting occur even under markedly different circumstances.

Since radiation sickness in many respects resembles motion sickness, Beeler and associates[4] conceived the idea of using Dramamine in this symptom complex. A small series of 23 patients was observed under the treatment with placebos for a period of four days. Radiation sickness developed in all. In this series, 79 per cent had good to excellent results under the influence of Dramamine. Parenthetically, the authors state that pyridoxine (200 mg.) given with Dramamine gave better results than Dramamine alone. Nausea and vomiting of pregnancy also appear to be relieved to a considerable extent.[5,6,7]

The mode of action of this drug is difficult to understand, since the etiologic factors are so varied. Among the other actions, such as general depression, anti-acetylcholine and local anesthetic actions, Dramamine and probably other antihistaminics may possibly possess, according to Beeler and associates the property of depressing more or less specifically the vomiting center.—A. L. TATUM, M. D.

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INTERNATIONAL COLLEGE OF SURGEONS ANNOUNCES CONVENTION DATES

The fifteenth Assembly of the United States chapter of the International College of Surgeons will be held in Cleveland, October 31–November 3, at the Cleveland Public Auditorium. The headquarters hotel will be the Cleveland Hotel. Convention details will be announced later.

Notes on Clinical Pathology

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Serum Bilirubin and the Van den Bergh Test

Serum Bilirubin

Bilirubin, the chief pigment of bile, is derived from the hemoglobin of disintegrating erythrocytes by a "break down" process in the cells of the reticuloendothelial system.[1] Immediately after formation the bilirubin combines with the albumin of the plasma to form a complex[2] which gives an indirect van den Bergh reaction only. The term *hemobilirubin*[3,4] is commonly used for this pigment which is normally present in small amounts in the blood stream. Parenchymatous cells of the liver are concerned with the excretion of bile pigment into the bile canaliculi and, unlike the Kupffer cells, do not seem to have a part in its manufacture. During the process of excretion the bilirubin-plasma albumin bond is broken, but the bilirubin remains loosely attached to the albumin as a dissociable complex. Excreted bilirubin gives a direct van den Bergh reaction in addition to an indirect reaction. The term, *cholebilirubin*, is often used for this pigment.[3,4]

The Van den Bergh Test

This test, introduced in 1913 as a method for the quantitative estimation of bilirubin,[5] is based upon Ehrlich's well known diazo reaction, i. e., the formation of a reddish or a reddish violet color in a solution of bilirubin when a mixture of sulphanilic acid, hydrochloric acid, and sodium nitrite is added. The color change is considered to be due to the formation of azobilirubin.

In the *indirect* van den Bergh reaction, alcohol must be added to the serum-reagent mixture for the full development of the color compound. The production of color without the addition of alcohol to a mixture of serum and reagent constitutes the *direct* van den Bergh reaction.

Through the years, many modifications of the test have been advocated, because of three main sources of error inherent in the original procedure, namely, (1) partial loss of bilirubin by adsorption on the protein precipitate after the addition of ethyl alcohol in the indirect reaction; (2) variations in the depth of color produced due to changes in pH, and (3) difficulty in obtaining a good color match with the standard solution originally recommended.

Recently, many laboratories have turned to the Ducci and Watson modification[6] of the Malloy and Evelyn method.[7] This procedure has the following advantages and features:

(1) In the indirect reaction adsorptive loss of bilirubin is prevented by the substitution of methyl alcohol for ethyl alcohol.

(2) Accurate color determinations are insured. Photoelectric instruments or spectrophotometers are calibrated with bilirubin solutions prepared from highly purified bilirubin powder.*

(3) A quantitative direct reading (one minute prompt reaction) is provided as well as a total bilirubin reading. The latter is made 30 minutes after the precipitation of proteins by methyl alcohol. The total bilirubin includes cholebilirubin (direct or prompt reacting bilirubin) and hemobilirubin (indirect reacting bilirubin).

A one minute direct reading is advocated, because Ducci and Watson's studies on sera and body fluids from patients with various types of jaundice indicate that nearly all of the direct reacting bilirubin present gives rise to azobilirubin within this period of time. Consideration is no longer given to so-called delayed and biphasic reactions described in the older literature. Available evidence indicates that these reactions are caused by variable amounts of hemobilirubin and cholebilirubin in the sera.

Further details of the Ducci and Watson modification of the Malloy and Evelyn method may be found in the next issue of this journal.—W. H. JAESCHKE, M. D.

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* Hoffman–LaRoche Co., Kingsland Road, Nutley, New Jersey or Eastman Kodak Co., Chemical Division, Rochester, New York.

. . . . The President's Page . . . .

A Question of Ethics

THREE years of controversy in the American Medical Association's House of Delegates culminated during the annual session in San Francisco, June 25–30, when a version of the so-called "Hess report" was adopted by the House.

Although its possible effects on hospital–medical relations are still unknown and its method of implementation uncertain, there are some preliminary observations to be drawn from the intentions that stimulated the discussion in the first place. The action of the House of Delegates was aimed at ending the long standing system under which hospitals hired physicians on a salary and sold their services for a profit. Contract practice per se is still not unethical. Most directly affected are the fields of pathology, radiology, anesthesiology, and physical medicine.

Now, the House of Delegates has declared that the physicians in these particular fields of practice are engaged in the practice of medicine to the same degree as are surgeons, internists, or any other specialists, and therefore are subject to the same codes of ethics and conduct. Many leaders in the hospital field contend to the contrary, saying that these fields are not medicine but "hospital services."

Efforts to resolve the dispute have, therefore, hinged upon the question of medical ethics. The physicians, in meeting assembled, have declared that contract practice for profit to a lay party in the doctor–patient relationship is unethical and that the four fields of specialization under discussion are truly the practice of medicine.

Every state in the union, except one, has a law declaring the corporate practice of medicine unethical. In addition, when a physician is felt to be unethically practicing medicine, the only course of action against him is through the local county medical society. The physician may appeal to the state society, and if still dissatisfied, to the Judicial Council of the American Medical Association. If it concurs that he is unethical, and the physician continues his unethical relationship with the hospital, the Judicial Council may inquire of the AMA Council on Medical Education and Hospitals as to why that hospital is not removed from the AMA list of approved hospitals.

Practical expediency will, no doubt, form the basis for hundreds of hospitals and clinics to continue paying salaried physicians while collecting profit-producing fees from their patients. Similarly, thousands of well trained nurses will continue to administer anesthetics, although this is the practice of medicine and, as such, should be performed only by a physician. It is doubtful that anesthesiology will ever attract enough physicians to remedy the shortage of anesthetists and permit them to meet the standards decreed by ethics.

In a nutshell, salaried physicians have been and will continue rendering excellent service to patients. Nurse anesthetists must continue to sit at the head of operating tables or many hospitals will close. The question of ethics is in reality a question of what is good for the public in a given locality. As long as the public need and interest is being properly served by whatever hospital-nurse-doctor-patient relationship exists in a certain area, the question of ethics should not assume an importance disproportionate to the health requirements of the community.

John Wm Tinitt MD

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

A. L. HUNTER

A graduate of Yale University School of Medicine, Doctor Hunter served a pediatric internship and residency at Babies and Children's Hospital, Cleveland, and Children's Community Center affiliated with Yale University School of Medicine, Department of Pediatrics. Since 1935 she has been chief of the Bureau of Maternal and Child Health of the State Board of Health.

Retrolental Fibroplasia—A New Health Problem

There is always some new challenge in the practice of medicine. Retrolental fibroplasia, a fairly recent disease entity, is one of those challenging conditions which has real public health and medical significance. The puzzle of its origin is not yet solved, but it is accounting for an ever increasing number of blind infants. Every physician will, therefore, want to watch for the condition and to follow the progress of special studies that are being made. The pooled observations and studies of many doctors may eventually clarify the cause.

Although a case was described in Chicago in 1937, Dr. F. L. Terry of Boston first focused medical attention on retrolental fibroplasia in 1942. His studies were based on the late manifestations of the disease which he assumed had prenatal origin. He pointed out that the condition occurred in premature infants, usually those weighing under 4 pounds at birth. His reports stimulated widespread interest and many follow-up studies have been made. The striking thing we do know is that incidence varies widely, not only between areas but within cities. Incidence is apparently higher in male infants. The disease is increasing more rapidly than can be accounted for by the increased survival of early premature infants. No direct correlations have been proved with any prenatal complications, maternal bleeding, fetal or neonatal anoxia, exposure to light, or the use of oxygen. Even earlier suggested correlations to lack of vitamin E; to the use of highly concentrated water-miscible solutions of fat-soluble vitamins A, D, and K in which the emulsifying agent was suspect; to the use of iron in early feedings; and to artificial feedings in general, have not been proved.

The careful studies of Drs. W. C. and E. U. Owens of Johns Hopkins University, based on routine weekly eye examinations of all premature infants in the susceptible group, have clarified the postnatal origin of the disease. They were able to show that the eyes of infants in whom retrolental fibroplasia developed were normal at birth. The first changes began at about the fourth week of life with the development of a grayish vascularized membrane behind the lens. In rapid succession the vessels in the membrane and in the retina dilated, adhesions occurred, and the vitreous became cloudy and pressure increased. Blindness resulted with the final detachment of the retina, occurring at about the fourth month. This particular disease entity, which usually affects both eyes, must be differentiated from retinoblastoma and congenital cataract. The latter conditions are usually present at birth, often unilateral, and frequently associated with other congenital anomalies. With retrolental fibroplasia the disease once started is rarely arrested. The very nature of the disease indicates why surgical removal of the membrane brings no benefit.

By routine observations, careful histories, and alertness we may some day learn the answer to this riddle now locked away in the intricate metabolic process of the human organism. Until that time the fate of any child afflicted with the disease may be materially influenced by early diagnosis and proper interpretation to parents. Adequate plans for any child blind from early in life should include referral to the division for handicapped children in the Department of Public Instruction, Madison, Wisconsin. Through individual home teaching and group instruction of parents they may be trained to help their handicapped children in such a way that each may lead a fairly normal life.—AMY LOUISE HUNTER, M.D., *Chief, Bureau of Maternal and Child Health.*

REFERENCES

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2. Kinsey, V. E., and Zacharias, L.: Retrolental fibroplasia, J.A.M.A. 139: 572–578, 1949.
3. Owens, W. C., and Owens, E. U.: Retrolental fibroplasia, Am. J. Pub. Health 40:405–408 (April) 1950.

Proceedings of the Milwaukee Academy of Medicine May 16, 1950

Clinical Use of Antihistamines*

By SAMUEL FEINBERG, M. D.
Chicago

THE clinical use of antihistamines is suggested from the historical background of allergic manifestations. Some fifty years ago it was first suggested that many of the anaphylactic shock symptoms were similar to those produced by the injection of histamine; therefore, it readily evolved that the manifestations of hypersensitivity may be related to a substance, such as histamine, which is liberated during the period of action. Many years followed during which histamine could not be separated and, therefore, many referred to "histamine-like reactions" produced by "histamine-like substances"; however, it is now true that histamine has been demonstrated in such instances and we speak of the phenomenon as a histamine reaction. Although there are many differences between anaphylaxis and clinical hypersensitivity diseases, there are a sufficient number of facets that are similar, and, therefore, the consideration of therapy may likewise be similar. The relationship between anaphylactic asthma in the guinea pig and clinical asthma in the human being, and hypertension in dog anaphylaxis and the vascular disease of man emphasizes the relationship. Furthermore, histamine substances demonstrated by cutaneous reaction when antigenic substances react with tissue further emphasize this relationship. One must grant that there are other considerations beside histamines in allergic phenomenon but it must be admitted that histamine is an important factor; therefore, the steps of therapy are directed in this direction.

A schematic representation of the relationship of histamine may be stated as follows: Cells contain histamine or its precursor but such is not detrimental to the well being of the organism. When a cell is sensitized by its reaction with a reagin, it becomes an allergic cell. On further contact with an allergin the sensitized cell liberates histamine and this free substance becomes active and produces a reaction in its area of liberation. This liberation is identified by its effect on smooth muscle, by its dilating action on capillaries, and by the increase in capillary permeability. If one treats a sensitized cell by the phenomenon of desensitization, the liberation of histamine can be blocked so that allergin contact in the future does not liberate a sufficient amount of histamine to produce a reaction.

The antihistamines are employed, however, in the instances in which this histamine substance is liberated and is active. On experimental basis it is proved that the antihistamines will inhibit the actions of histamine-produced reactions. Since one cannot judge the amount of histamine present from the degree or type of reaction, the dosage of the drug is difficult to evaluate. On the other hand, it is not at all certain that some of the histamine which is liberated may have beneficial effects and is necessary for normal functions in some parts of the body. Another consideration is that all of the antihistaminic drugs are local anesthetics, but this action has nothing to do with the correction of histamine reactions. Some of the antihistamines are also epinephrine potentiators which may in some measure be responsible for relief of symptoms. It must be clearly pointed out that all of these drugs, without exception, are cerebral excitants. This is true in all the experimental animals as well as in human beings. The most important clinical consideration is that infants and children are greatly susceptible to this effect of the antihistamines.

The application of these drugs in clinical therapy is best in hay fever, where good results are obtained in many cases. In complicated hay fever with asthma the effects are considerably less striking than in simple hay fever. Likewise, in severe asthma when there is very intense congestion and edema of the tissue, the effect is considerably less. In atopic dermatitis these agents are only moderately effective and in contact dermatitis not as effective. The use of these drugs in all other instances, such as gastrointestinal allergy, headaches, irradiation sickness, and colds, has not been with striking benefit. Particular mention should be made of the use of such agents in the treatment of a common cold. Since it has been suggested that the first stage of a cold is an allergic phase to which is added the inflammatory reaction of virus and bacterial type it, therefore, might be logical to prevent the initial allergic phase and thereby remove the favorable conditions for bacterial and viral growth in the respiratory passages. However, in my control experiments it has been shown that such is not the result—the reports to the contrary notwithstanding. Perhaps the only benefit might be the temporary reduction in the secretions and thereby some relief of the hyperesthesia. Personally I have found that the use of the antihistamines in the question of the

* The complete paper by Doctor Feinberg is available from the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3.

cold serves more as a diagnostic reagent to distinguish between allergic rhinitis or intercurrent colds or questionable colds rather than in the therapy of a common cold.

The dose of antihistamines is difficult to discuss. There is no set dosage for any of the diseases. One must learn by experience the tolerance of an individual to these agents. It is true in many of the instances in which the drug is indicated and the response is not forthcoming that one must increase the dosage. It is my experience that this is done with considerable reluctance by the practitioners. Most of the drugs are active in three or four hours and, therefore, must often be repeated. In the instances of nausea and vomiting it is particuarly difficult to maintain an adequate dosage, and in such instance one may need to use parenteral administration. This type of administration, however, is used only as an exception and is not the rule even in the emergency attacks, such as angioneurotic edema of the larynx; wherein, Adrenalin serves a better purpose. The question of dosage must also be considered in reference to the area involved. In some instances of vasomotor rhinitis or bronchial asthma some of these drugs given topically by sprays serve a better purpose. Apparently this is due only to the greater concentration in the local site. One must, however, remember that in the therapy of skin diseases, such as atopic dermatitis, one may actually increase the irritation of the skin by local applications of these agents and actual contact type of sensitization may result with the application of antihistamines to the skin.

A very important question refers to the drug to be used. I have classified the drugs into three groups. This is based on the degree of sedative effect. In the group in which sedation is prominent there is the drug Benadryl. In the moderately sedative drugs there is Pyribenzamine. In the very mildly sedative drugs there is Antistine. I would recommend that practitioners be acquainted with some of the drugs in each of these groups and use them according to the patient. Those who are easily sedated would be treated with the milder drug and those who require sedation might be treated with drugs such as Benadryl. Although the therapeutic effects of the various drugs on the market vary somewhat, the question of degree of sedation is probably just as or even more important. It is true that with adequate therapy some individuals may be made quite sleepy and thereby potentially dangerous to themselves and to others from the standpoint of accidents. Other side effects include those of convulsions, particularly in children; excessive drying of pharyngeal and respiratory secretions; nausea; heart burn; diarrhea; and agranulocytosis.

In summary, then, the use of antihistamines is based on the knowledge that hypersensitivity reactions are related to the action of histamine. The drug used is judged by the clinical response and its side effects, particularly sedation. Drugs are most often given by mouth, the dosage of which must be individualized for each patient. These agents are of no particular value in the treatment or prevention of the common cold.

UNIVERSITY OF MINNESOTA TO PRESENT COURSE IN NEUROLOGIC ROENTGENOLOGY

The University of Minnesota has announced that a continuation course in neurologic roentgenology will be presented at the Center for Continuation Study on October 30 to November 4, 1950. Distinguished visiting physicians who will participate as faculty members of the course include Drs. Arthur E. Childe, Winnipeg; Philip J. Hodes, Philadelphia; Dabney Kerr, Iowa City; and Knut Lindblom, Stockholm, Sweden. Clinical and full time members of the staff of the University of Minnesota and Mayo Foundation will complete the faculty for the course.

Presentations on the anatomy and pathology of the central nervous system will be given early in the course. Emphasis will be placed throughout on different technics available for the roentgen examination of the central nervous system. Correlation of clinical and roentgenologic findings will be emphasized.

CECIL PALMER

"STATE MEDICINE-PROMISE AND FULFILLMENT"

The STATE MEDICAL SOCIETY of WISCONSIN
J. W. TRUITT, M. D., PRESIDENT
161 WEST WISCONSIN AVENUE
Milwaukee (3)

July 15, 1950

Dear Doctor:

I am pleased to announce that our Annual Meeting dinner speaker on Tuesday evening, October 3, will be Mr. Cecil Palmer, England.

We are fortunate to secure the services of Mr. Palmer, who has made such a fine impression on his American audiences in giving them a critical analysis of the events in England, which culminated in the rise of the Labour Government and the Welfare State. His message is of special importance as he is in no way connected with the medical profession, but speaks as a consumer of medical care and as a citizen of England who is deeply concerned with the continued welfare of his country and fellow citizens.

I know that Mr. Palmer's address will be of great interest to you, and to your wife if she is accompanying you to the Milwaukee meeting.

Within the next several days you will receive in the mail an announcement for the round-table luncheons. With this announcement there will be a slip for luncheon and dinner reservations. I would suggest that you make your dinner reservations at the same time you make your reservations for the noon luncheons, as I anticipate that the demand for dinner tickets will exceed the number which can be accommodated.

Sincerely yours,

John Wm Truitt MD

J. Wm. Truitt, M.D.
President

[SEE PAGE 627 FOR DINNER RESERVATION]

SECTION CHAIRMEN ANNOUNCE SPEAKERS

MEETINGS HELD ON WEDNESDAY AFTERNOON, OCTOBER 4

INTERNAL MEDICINE

V. F. LANG, M. D., Milwaukee, Chairman

Speakers:

Recent Advances in the Use of BAL: ELSTON L. BELKNAP, M. D., Milwaukee

ACTH and Cortisone: JEROME W. CONN, M. D., Ann Arbor, Michigan

Bacterial and Non-Bacterial Infections of the Respiratory Tract: YALE KNEELAND, M. D., New York City

Acute Aseptic Meningitis: W. D. SUTLIFF, M. D., Memphis, Tennessee

OBSTETRICS & GYNECOLOGY

J. F. EGAN, M. D., La Crosse, Chairman

Speakers:

The Surgical Management of Uterine Prolapse: B. E. URDAN, M. D., Milwaukee

Advances in the Treatment of Cancer of the Cervix, and Evaluation of the Surgical Management: MICHAEL J. JORDAN, M. D., New York City

Chorionepithelioma of the Uterus: CHARLES W. MUELLER, M. D., New York City

The Obstetrician's Responsibility in the Problem of Prematurity: J. W. HARRIS, M. D., Madison

OPHTHALMOLOGY & OTOLARYNGOLOGY

EDWARD J. ZEISS, M. D., Appleton, Chairman

Speakers:

Retinal Detachment: WILLIAM F. HUGHES, JR., M. D., Chicago

Acoustic Trauma: MEYER S. FOX, M. D., Milwaukee

Ocular Sarcoidosis: AUSTIN G. DUNN, M. D., Stevens Point

Practical Approaches to Otolaryngology: FRANCIS L. LEDERER, M. D., Chicago

PEDIATRICS

K. B. McDONOUGH, M. D., Madison, Chairman

Speakers:

Diagnosis and Treatment of Fibrocystic Disease of the Pancreas: JOHN E. GONCE, JR., M. D., Madison

The Treatment of Disturbances in Water and Electrolytes in Infantile Diarrhea: DANIEL C. DARROW, M. D., New Haven, Conn.

Problems in Pediatric Surgery: A. A. SCHAEFER, M. D., Milwaukee

The Factors Which Affect Growth as Measured by Nitrogen and Calcium Studies: JOSEPH A. JOHNSTON, M. D., Detroit

RADIOLOGY

H. H. WRIGHT, M. D., Milwaukee, Chairman

Speakers:

The Physiologic and Anatomic Basis for Roentgen Diagnosis of Pulmonary Disease: LEO RIGLER, M. D., Minneapolis

Radiation Therapy of Intracranial Neoplasms: H. DABNEY KERR, M. D., Iowa City

The balance of the program will consist of case reports by Wisconsin radiologists. Details will be found in the complete program published in the August *Journal.*

SURGERY

FORRESTER RAINE, M. D., Milwaukee, Chairman

Speakers:

The Surgical Management of Carcinoma of the Colon: F. D. WEEKS, M. D., Ashland

Surgical Repair of Radiation Lesions, Including Those of Atomic Origin: J. BARRETT BROWN, M. D., St. Louis

Subtotal Gastrectomy in the Treatment of Peptic Ulcers: W. B. GNAGI, M. D., Monroe

Present Status of Surgery of the Pancreas: RICHARD CATTELL, M. D., Boston

Did You See?

The June issue carried a list and description of demonstrations to be held each morning from 9:00–10:20. This is an important new feature of the Annual Meeting and we urge your participation through attendance. There is too much for you to see and hear on one day, so plan to devote three mornings to these direct teaching demonstrations!

Plan to Attend ALL THREE *Days*

The 1950 Annual Meeting program is replete with outstanding features. We urge that you plan your schedule so you can be in attendance *all three days.*

MONDAY: Teaching demonstrations . . . 8 of them! . . . 3 hospital staff conferences, with use of patients . . . Smoker, Monday evening. Lots of fun and good fellowship . . . Full schedule of round-table luncheons.

TUESDAY: More teaching . . . See June *Journal* for demonstrations between 9:00–10:20 a. m. Big names on general program, both in late morning and in afternoon . . . Cecil Palmer, brilliant English lecturer, as speaker for dinner Tuesday evening . . . annual awards to members of "50 Year Club."

WEDNESDAY: Still more teaching at the Auditorium in the morning. Also big names on general session program in late morning . . . Many out-of-state speakers as round-table leaders . . . Full afternoon of scientific programs by sections!

SEE AUGUST *JOURNAL* FOR COMPLETE PROGRAM

SCIENTIFIC

ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

MONDAY ★ HOTEL SCHROEDER ★ OCTOBER 2

FOURTH FLOOR MEETING ROOMS

1. Parlor A: RHEUMATIC HEART DISEASE: Hugh McCulloch, M. D., LaRadida Jackson Park Sanitarium, Chicago
2. Parlor B: COMMON NEUROLOGIC PROBLEMS: A. B. Baker, M. D., professor of neurology, and head of division of neurology, University of Minnesota Medical School
3. Parlor C: NEWER DRUGS AND THEIR USES: W. S. Middleton, M. D., professor of medicine and dean, University of Wisconsin Medical School
4. Parlor D: ACUTE NEPHRITIS: F. D. Murphy, M. D., clinical professor and director of division of radiology, Marquette University School of Medicine
5. Parlor E: INFERTILITY: Roland Cron, M. D., professor and head of the department of obstetrics and gynecology, Marquette University School of Medicine
6. Parlor F: ACTH AND CORTISONE: E. S. Gordon, M. D., associate professor of medicine, University of Wisconsin Medical School
7. Parlor H: VIRUS DISEASE PREVENTION: A. R. Zintek, M. D., director of preventable diseases, Wisconsin State Board of Health
8. Parlor I: PROBLEMS IN ANESTHESIA: Stuart C. Cullen, M. D., associate professor of surgical anesthesia, University of Iowa College of Medicine

SPECIAL LUNCHEON—FOURTH FLOOR

9. Parlor G: Past President's Luncheon: Guest luncheon for all past presidents of the SMS and President-Elect. By invitation only. No charge for luncheon.

FIFTH FLOOR MEETING ROOMS

10. Private Dining Room 507: PRESENT STATUS OF SURGICAL TREATMENT OF THYROID DISEASE: Carl Eberbach, M. D., clinical professor and director of division of surgery, Marquette University School of Medicine
11. Private Dining Room 508: MANAGEMENT OF HAND INJURIES: William Frackelton, M. D., assistant clinical professor of surgery, Marquette University School of Medicine
12. Private Dining Room D: RH PROBLEMS: Tibor Greenwalt, M. D., clinical instructor in medicine, Marquette University School of Medicine
13. Committee Room: ERUPTIONS OF THE HANDS AND FEET: S. A. M. Johnson, M. D., professor of dermatology and syphilology, University of Wisconsin Medical School
14. Pine Room: RECENT ADVANCES IN HEMATOLOGY: John Hirschboeck, M. D., professor of medicine and dean of Marquette University School of Medicine
15. Pere Marquette Room: DISCUSSION OF SOME PROBLEMS OF GYNECOLOGIC PLASTIC SURGERY: Ralph Campbell, M. D., professor of obstetrics and gynecology, University of Wisconsin Medical School

SPECIAL LUNCHEON—FIFTH FLOOR

16. East Room: County Secretaries: Special luncheon for county secretaries, furnished by SMS, at which county officers will meet with SMS and AMA officials.

Note: No charge for this luncheon, so do not include payment in your reservation.

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SCIENTIFIC

ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

TUESDAY ★ HOTEL SCHROEDER ★ OCTOBER 3

FOURTH FLOOR MEETING ROOMS

1. Parlor A: PSYCHOTHERAPY IN GENERAL PRACTICE: John Schindler, M. D., Monroe
2. Parlor B: DRUGS IN THE CONTROL OF PAIN: Harry Beckman, M. D., professor and director, department of pharmacology, Marquette University School of Medicine
3. Parlor C: ANTIBIOTICS IN OTOLARYNGOLOGY: Francis Lederer, M. D., professor of otolaryngology and head of department of otolaryngology and rhinology, University of Illinois College of Medicine, Chicago
4. Parlor D: VIRUS INFECTIONS OF THE NERVOUS SYSTEM: W. D. Sutliff, M. D., V. A. Hospital, Memphis, Tennessee
5. Parlor E: SURGICAL TREATMENT OF ADVANCED CARCINOMA OF THE PELVIS: Michael J. Jordon, M. D., associate professor of clinical obstetrics and gynecology, New York University–Bellevue Medical Center, New York City
6. Parlor F: THE MANAGEMENT OF HYPERTENSION: Chester M. Kurtz, M. D., associate professor of medicine, University of Wisconsin Medical School
7. Parlor G: CANCER OF THE PROSTATE: John B. Wear, M. D., associate professor of urology, University of Wisconsin Medical School
8. Parlor H: PULMONARY TUBERCULOSIS: A. V. Cadden, M. D., associate clinical professor of medicine, Marquette University School of Medicine

FIFTH FLOOR MEETING ROOMS

9. Parlor I: NON-GLOMERULONEPHRITIC RENAL DISEASE: W. A. D. Anderson, M. D., professor of pathology, Marquette University School of Medicine
10. Private Dining Room 507: NEWER DRUGS AND THEIR USES: Ovid Meyer, M. D., professor of medicine, University of Wisconsin Medical School
11. Private Dining Room 508: CARDIAC ARRHYTHMIAS: Francis F. Rosenbaum, M. D., assistant clinical professor of medicine, Marquette University School of Medicine
12. Private Dining Room 509: DIABETES MELLITUS: Bruno J. Peters, M. D., clinical instructor in medicine, Marquette University School of Medicine
13. Committee Room: UTERINE SURGERY: Paul Doege, M. D., Marshfield
14. Pine Room: THE MANAGEMENT OF ALCOHOLISM: Fritz Kant, M. D., professor of neurology and psychiatry, University of Wisconsin Medical School
15. Pere Marquette Room: BACK ACHE: Robert E. Burns, M. D., professor of orthopedic surgery, University of Wisconsin Medical School

SPECIAL LUNCHEON—FIFTH FLOOR

16. Ballroom: COMMON ADMINISTRATIVE AND PERSONAL TAX PROBLEMS CONFRONTING PHYSICIANS: Mr. Robert Murphy, Madison, legal counsel of the SMS and Mr. Alfred Granum, Amery, insurance specialist.

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SCIENTIFIC

ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

WEDNESDAY ★ HOTEL SCHROEDER ★ OCTOBER 4

FOURTH FLOOR MEETING ROOMS

1. Parlor A: MANAGEMENT OF COMPOUND INJURIES OF THE FACE AND JAWS: J. Barrett Brown, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis
2. Parlor B: MENINGITIS: Yale Kneeland, M. D., associate professor of medicine, Columbia University, New York City
3. Parlor C: THE SELYE ALARM REACTION IN CLINICAL MEDICINE: Jerome W. Conn, M. D., associate professor of internal medicine, University of Michigan Medical School, Ann Arbor
4. Parlor D: WATER AND ELECTROLYTE BALANCE: Daniel C. Darrow, M. D., professor of pediatrics, Yale University School of Medicine, New Haven, Conn.
5. Parlor E: CHRONIC INTESTINAL INDIGESTION: Joseph A. Johnston, M. D., pediatrician-in-chief, Henry Ford Hospital, Detroit
6. Parlor F: IRRADIATION THERAPY OF PELVIC NEOPLASMS: H. Dabney Kerr, M. D., professor of radiology, University of Iowa College of Medicine, Iowa City
7. Parlor G: PROBLEMS IN PEDIATRIC SURGERY: P. F. Hausmann, M. D., clinical instructor in surgery, Marquette University School of Medicine
8. Parlor H: WHAT'S NEW IN POISONS?: Elston L. Belknap, M. D., associate clinical professor of medicine, Marquette University School of Medicine
9. Parlor I: EMOTIONAL DEVELOPMENT IN CHILDREN: H. Kent Tenney, Jr., M. D., associate professor of pediatrics, University of Wisconsin Medical School
10. Private Dining Room 507: MASS SURVEY ROENTGEN EXAMINATIONS: Leo Rigler, M. D., professor of radiology, University of Minnesota Medical School

FIFTH FLOOR MEETING ROOMS

11. Private Dining Room 508: ULCERATIVE COLITIS: Richard Cattell, M.D., Lahey Clinic, Boston
12. Private Dining Room 509: AIDS TO RURAL PRACTITIONERS IN THE RECOGNITION OF EARLY CANCER (Including Biopsy and Other Techniques): W. D. Stovall, M. D., professor of hygiene, University of Wisconsin Medical School and director of State Laboratory of Hygiene; and A. R. Curreri, M. D., associate professor of surgery, University of Wisconsin Medical School
13. Committee Room: (To be announced)
14. Pine Room: PAINFUL SHOULDERS: Herman Schumm, M. D., associate clinical professor of orthopedic surgery and director of department of orthopedic surgery, Marquette University School of Medicine
15. Pere Marquette Room: OBSERVATIONS ON THE PATHOLOGY OF FIBROCYSTIC LESIONS OF BONE: G. A. Bennett, M. D., professor of pathology, University of Illinois College of Medicine, Chicago

Note: After luncheon the Wisconsin Society of Pathologists will meet, but luncheon for general practitioners as well as pathologists.

SPECIAL LUNCHEON—FIFTH FLOOR

16. East Room: EENT Luncheon. Special luncheon for all those attending Section meeting. Informal discussion of EENT problems following luncheon and preceding afternoon scientific program. *All EENT members please register for this luncheon.*

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Luncheon and Dinner Reservations

If you have not already done so, send in your luncheon and dinner reservations *today*. Many luncheons are already filled, so *be sure to list below* **three** *selections*, in order of preference, for each of the days you will be in attendance.

Mail to: C. H. CROWNHART, Secretary
State Medical Society of Wisconsin
704 East Gorham Street
Madison 3, Wisconsin

Cost of Luncheons: $2.00 per plate (Including gratuities)

Cost of Dinner : $4.00 per plate (Including gratuities)

Luncheon for MONDAY, OCTOBER 2

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Luncheon for TUESDAY, OCTOBER 3

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Luncheon for WEDNESDAY, OCTOBER 4

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Dinner— TUESDAY, OCTOBER 3

Reserve _____ places for me at $4.00 per plate.

Signed _____

Address _____

(*Make Your Check Payable to:* THE STATE MEDICAL SOCIETY OF WISCONSIN)

Society Proceedings

Calumet

Following a dinner at the Old Mill in Hayton on May 12, members of the Calumet County Medical Society held a business meeting while their wives conducted the annual election of the Auxiliary to the Society. A constitution and by-laws were adopted to replace the original ones, which had been lost. *Dr. Kenneth Humke*, Chilton, chairman of the public relations committee, discussed the proposed immunization program for 1950 and 1951.

Dodge

Members of the Dodge County Medical Society entertained their wives at a dinner dance at the Rock River Country Club on June 3.

Fond du Lac

Dr. William R. Kreul of Racine was the guest speaker at a meeting of the Fond du Lac County Medical Society at Schreiner's Resturant in Fond du Lac on June 1. He discussed "The Anesthesiologist in the Community Hospital." Two physicians were appointed members of the Fond du Lac Community Welfare Council.

Grant

Meeting at Leiser's Gardens in Dubuque, Iowa, on May 11, members of the Grant County Medical Society heard talks by two Dubuque physicians: Dr. Donald Conzett discussed "Fractures of the Forearm and Arm," and Dr. Kenneth Hazlett spoke on "Cardiac Irregularities." A talk was also given by *Dr. E. M. Dessloch*, Prairie du Chien, Fourth District Councilor. At the business session it was voted to continue the vaccination program and to sponsor a 4–H award.

Green Lake—Waushara

A Madison pediatrician, *Dr. H. Kent Tenney*, was the guest speaker at the June 20 meeting of the Green Lake–Waushara County Medical Society held in Berlin. Doctor Tenney spoke on "Preventing Behavior Problems in Children."

Marathon

Dr. Joseph F. Smith, veteran surgeon at Wausau, was honored by his colleagues in the Marathon County Medical Society at the Wausau Club in Wausau on June, the fiftieth anniversary of his graduation from Rush Medical College and the beginning of his internship at Presbyterian Hospital, Chicago. A bouquet of fifty yellow roses was presented to the doctor by *Dr. A. H. Stahmer*, president of the Society, in behalf of the group. Doctor Smith, a past-president of the State Medical Society, located in Wausau in 1908, where he has served as chief of staff of St. Mary's Hospital since the organization of the staff. He has participated actively in medical affairs locally and nationally, having served for two terms as president of the Marathon County Medical Society and for one term as president and 32 years as secretary of the Ninth Councilor District Medical Society. In 1919 he was an alternate delegate to the American Medical Association and from 1921 to 1942 he served as delegate to that body. In 1937 he was the recipient of the Council Award of the State Medical Society, the highest award conferred by that organization.

Marinette

Two members of the staff of Wayne University College of Medicine, Detroit, were guest speakers at a joint meeting of the Marinette County Medical Society and the Menominee (Mich.) County Medical Society at the Riverside Country Club in Menominee on May 17. Dr. R. J. Noer, assistant professor of surgery, spoke on "Surgical Aspects of Upper Gastrointestinal Tracts," and Dr. S. J. Jacobson, assistant professor of medicine, presented a paper on "Borderline Lesions of the Gastrointestinal Tract."

Portage

Dr. W. E. Wellman, a member of the staff of the Mayo Clinic, Rochester, Minn., spoke before a meeting of the Portage County Medical Society on June 6 at the home of *Dr.* and Mrs. *Frank Iber*, Stevens Point. He talked on "Newer Concepts in Antibiotic Therapy."

Price—Taylor

Following a dinner at the Skyline in Phillips on May 27, members of the Price–Taylor County Medical Society gathered at the Phillips High School, where they heard talks by two Milwaukee physicians. Dr. Philip Feingold discussed the "Diagnosis and Early Recognition of Bronchiogenic Carcinoma," and *Dr. Leon Hirsh* presented a paper on the "Treatment of Cough." At the business session the following officers were reelected: *Dr. J. D. Leahy*, Park Falls, president; *Dr. W. W. Meyer*, Medford, vice-president; and *Dr. J. L. Murphy*, Park Falls, secretary-treasurer.

Sheboygan

The Sheboygan County Medical Society on May 19 issued the following resolution in tribute to *Dr. T. E. Malloy* of Random Lake, who died on May 9:

WHEREAS, the death of Doctor T. E. Malloy has removed from our ranks a physician who has served his community for more than a half century, and

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Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1949, Xanthine Derivatives, Philadelphia, J. B. Lippincott Company, 1949, p. 323.

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WHEREAS, his constant devotion to professional responsibilities has always served as an inspiration to colleagues, and

WHEREAS, his time and energies were given unselfishly to any project for the improvement of his community despite the pressure of his professional duties,

Now, therefore be it resolved, by the Sheboygan County Medical Society that our sympathies be extended to the family in their bereavement and that a copy of these sentiments be presented to them.

Be it further resolved, that copies of this resolution be incorporated in the proceedings of this society and that copies be sent to The Sheboygan Press and to the village board of Random Lake.

Waukesha

Three representatives from the State Medical Society discussed the Wisconsin Plan and Wisconsin Physicians Service, the two insurance plans approved by the State Society, at a meeting of the Waukesha County Medical Society at the Avalon Hotel, Waukesha, on June 7. Speakers were Mr. C. H. Crownhart, secretary of the State Medical Society; Mr. Ralph Weber, executive director of Wisconsin Physicians Service; and Mr. Thomas J. Doran, director of the Wisconsin Veterans Medical Service Agency.

Winnebago

Mr. Ralph Weber, executive director of Wisconsin Physicians Service, was the guest speaker at a meeting of the Winnebago County Medical Society at the Hotel Menasha in Menasha on June 1. His subject was "Past, Present and Future Medical Service."

Central Wisconsin Society of Ophthalmology and Otolaryngology

The Central Wisconsin Society of Ophthalmology and Otolaryngology held a two day meeting in Fond du Lac on June 3 and 4. The scientific programs were presented at St. Agnes Hospital, and a dinner was served on Saturday evening at the Hotel Retlaw. The program opened on Saturday afternoon with a paper on "The Treatment of Hearing Loss" by Dr. Lawrence R. Boies, Minneapolis. Dr. Theodore G. Martens, Rochester, Minn., then spoke on "The Non-Surgical Treatment of Strabismus," and the session closed with a discussion on "The Office Diagnosis of Head Conditions" by *Dr. W. J. Frawley* of Appleton.

Following a business meeting on Sunday morning, Miss Celeste Carlyle, a representative of Uhleman Optical Company, discussed counseling in optical style. Doctor Boies spoke on "The Management of the Patient Who Complains of Being Dizzy," and Doctor Martens discussed "The Management of Early Presbyopia."

Wisconsin Heart Association

Voluntary campaign workers were honored at the annual dinner meeting of the Wisconsin Heart Association at the Park Hotel, Madison, on June 10, for their contributions to the 1950 heart fund drive. Each of the 51 campaign chairmen was presented a certificate of appreciation by Mr. Glen V. Rork, Eau Claire, state campaign chairman. Dr. George E. Fahr, professor of medicine at the University of Minnesota Medical School, was the featured speaker at the dinner. His subject was "High Blood Pressure."

The dinner meeting followed a scientific program and election held at the Wisconsin General Hospital. The following papers were presented by Madison physicians during the morning scientific session: "Friedreich's Ataxia in Five Siblings, all with Similar Cardiac Involvement," *Dr. Thomas Lorenz;* "Experience in the Surgical Treatment of Patent Ductus and Coarctation of the Aorta," by *Dr. Joseph W. Gale;* "Cardiovascular Aspects of Local Anesthetic Toxicity," by *Dr. John Steinhaus;* "Subenon in the Treatment of Chorea," by *Dr. J. L. Sims,* "Radioactive Iodine in the Treatment of Goiter," by *Dr. E. C. Albright;* and "Rheumatic Fever Treated with Cortisone," by *Dr. E. S. Gordon.* Following a luncheon at the hospital, 4 cases were presented at a clinical-pathologic conference by *Drs. John K. Curtis,* Madison; *Francis Rosenbaum,* Milwaukee; *Francis Gehin,* Stevens Point; and George Fahr, Minneapolis.

Doctor Rosenbaum, an assistant professor at Marquette University School of Medicine, was later elected president of the organization. *Dr. Robin N. Allin,* Madison, was named president elect; *Dr. Lamont R. Schweiger,* Milwaukee, vice-president; and Mr. Leon R. Wheeler, Milwaukee, secretary-treasurer.

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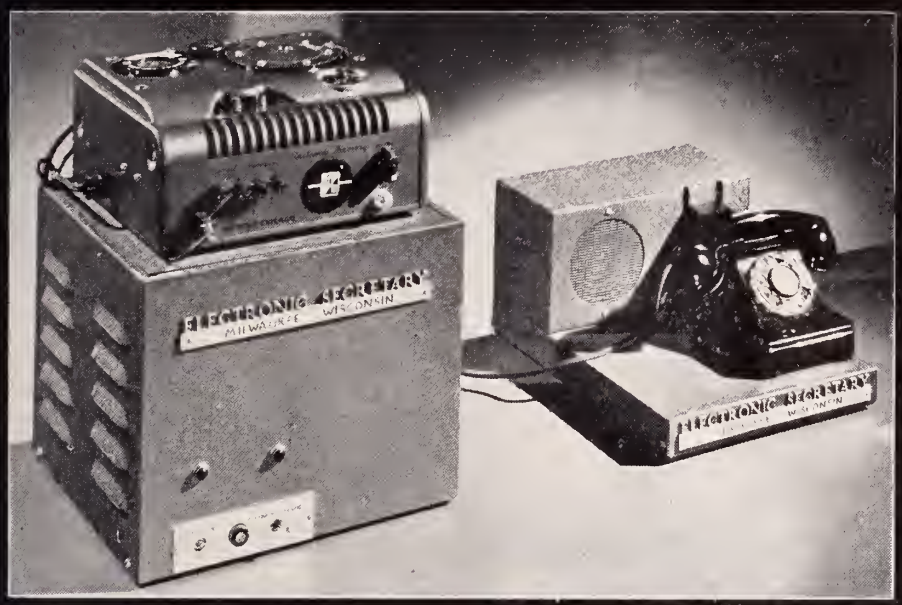

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News Items and Personals

Dr. F. P. Foley Honored at Dorchester

F. P. FOLEY

The village of Dorchester declared May 27 a legal holiday, and throngs of citizens turned out for the occasion to pay tribute to the physician who has ministered to them since 1909. Doctor Foley Day, honoring *Dr. F. P. Foley*, marked the fiftieth year of his medical practice, more than forty of which have been spent in Dorchester.

Principal speaker for the occasion was Mr. H. C. Ahrnsbrak, who is associated with the University of Wisconsin Extension Center in Wausau. His talk was entitled "Community Service." The observance began with a special High Mass for the doctor and his family. Following a parade, bands from high schools in the area provided music and the "babies" delivered by Doctor Foley passed in review. A purse was presented to him and his wife. The celebration was climaxed with a banquet and a dance.

Three physicians who graduated from Rush Medical College with Doctor Foley were present and spoke briefly: *Dr. Hart Beyer*, Pittsville; *Dr. H. H. Kleinpell*, Prairie du Chien; and *Dr. C. W. Leonard*, Fond du Lac. Other physicians attending the celebration were *Drs. Lyman A. Copps*, Marshfield; *H. H. Christofferson*, Colby; *A. L. Schemmer*, Colby; *L. E. Nystrum*, Medford; B. H. Dike, Owen; *G. G. Shields*, Abbotsford; *Harold Pomainville*, Nekoosa; and *D. J. Twohig*, Fond du Lac.

Doctor Foley, a native of Montello, began his first practice at Neshkoro. In 1909 he moved to Dorchester, where, in addition to his medical practice, he served for several years as village president.

Dr. E. J. Kerscher Honored by Casco Residents

A celebration marking thirty-six years of medical service at Casco by *Dr. E. J. Kerscher* was held by St. Peter's Church in that community on June 18. The day was designated as Doctor Kerscher Day. The celebration was ushered in with a Mass of thanksgiving at the church, and following a parade and a short program, a banquet was served in the church parlors at noon. During the afternoon there was a general homecoming program, and the event closed with a dance.

Doctor Kerscher, a lifelong resident of the town of Lincoln, received his medical degree from Marquette University School of Medicine. Following graduation in 1914 he returned to Lincoln, where he has continued in practice since.

A guest congratulates Dr. F. G. Peehn on the observance of Doctor Peehn Day in Sturtevant on May 13. In the receiving line with the doctor are his wife, and his daughter and son-in-law, Mr. and Mrs. William Davidson of Racine. Mr. Davidson holds a plaque presented to the doctor. (Story in June issue of the *Journal.*)

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Esophageal Surgery, One Week, starting October 16.
Breast & Thyroid Surgery, One Week, starting October 2.
Thoracic Surgery, One Week, starting October 9.
Gallbladder Surgery, Ten Hours, starting October 23.
Fractures & Traumatic Surgery, Two Weeks, starting October 9.
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Gastroscopy, Two Weeks, starting July 17, September 25.
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Clintonville Surgeon To Serve on Veterans Hospital Staff

Dr. John D. German, Clintonville surgeon, was recently appointed a consultant in surgery to the new 250 bed Veterans Administration Hospital at Iron Mountain, Mich. A member of the American College of Surgeons and a diplomate of the American Board of Surgery, the doctor will maintain his practice at Clintonville, travelling to Iron Mountain once a week for consultation.

Dr. G. J. Hathaway Named Chief Surgeon at King

Dr. G. J. Hathaway, King, was recently appointed chief surgeon of the Grand Army Home for Veterans at King. The appointment was effective June 1. Formerly the assistant surgeon at King, Doctor Hathaway succeeds *Dr. E. F. Hafemeister,* who will remain on the staff.

Dr. Roger Gray Becomes Associated With Father

Dr. Roger Gray, formerly of Madison, on July 1 became associated in the practice of medicine with his father, *Dr. R. J. Gray,* at Evansville. He has been an assistant physician in the department of preventive medicine and student health at the University of Wisconsin Medical School the past year.

Dr. W. B. Hildebrand Speaks to Hospital Staff

Dr. W. B. Hildebrand, Menasha, was the principal speaker at a meeting of the staff of Theda Clark Memorial Hospital at Neenah on May 26. His topic was "Diagnostic Clues Derived from Blood Pressure Readings."

Delavan Physician Attends Postgraduate Course

Dr. Harold Werbel, Delavan physician, recently attended a course in glandular diseases given by the American College of Physicians at the University of Illinois College of Medicine. Doctor Werbel is on the staff of the Lakeland Clinic in Delavan.

Sanitorium Superintendent Addresses Optimist Club

Dr. Raymond Evers, superintendent of Rocky Knoll Sanitorium, Plymouth, discussed the progress made in recent years in the treatment of tuberculosis to members of the Sheboygan Optimist Club at a meeting on May 24. The doctor explained modern technics and drugs used to treat the disease and described surgical treatments that are effective.

Dr. Elizabeth Baldwin Heads Legion Auxiliary

Dr. Elizabeth Baldwin of Marshfield was elected president of the American Legion Auxiliary of that city on June 5. Doctor Baldwin is also head of the Marshfield Business and Professional Women's Club.

Dodgeville Physician Opens Office in Linden

Dr. Sidney Jackson, Dodgeville physician, recently opened an office in Linden, where he will see patients two days a week. Before entering practice in Dodgeville, Doctor Jackson was on the staff of the Jackson Clinic in Madison.

Dr. E. A. Bachhuber Addresses Mayville Students

Dr. Edward A. Bachhuber, Milwaukee, was the guest speaker at a banquet held in Mayville on May 25 honoring students active in extracurricular activities this past year. Doctor Bachhuber, an associate in anatomy at Marquette University School of Medicine, spoke on the value of participation in extracurricular activities and emphasized that students should learn self-discipline during their high school careers.

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"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. M. D. Davis Honored by Milton College

Dr. M. D. Davis, Milton physician, received the annual alumni citation at the commencement exercises of Milton College on June 15. The award, entitled "Pillar of Milton," is awarded annually by the alumni association to one who has made on outstanding contribution to his alma mater. The citation read as follows:

The Alumni Association of Milton College takes pride in honoring with this citation, Milton Daland Davis, on this, the twenty-sixth anniversary of his graduation, as one who has made an outstanding contribution to his Alma Mater; whose spirit of generosity, wide acquaintance and respect among Milton alumni, many years' activity as alumni secretary, member of the board of trustees and director of the student health service bear evidence of his loyalty to and support of his college.

In token of our regard, we hereby declare Milton Daland Davis to be a Pillar of Milton.

Madison Physician Begins Plastic Surgery Residency

Dr. James F. McIntosh, formerly of Madison, left on June 15 for New Orleans, where he will become a resident in plastic surgery at Charity Hospital. The doctor, a son of *Dr. R. L. McIntosh*, also of Madison, has been in residency in surgery at Madison General Hospital for the past two years.

Dr. A. A. Quisling Addresses Meeting in Paris

Dr. A. A. Quisling, Madison, sailed from New York on June 7 for Paris, where he presented a paper at the International Congress on Cancer. The doctor discussed the microscopically controlled chemosurgical treatment of cancer of *Dr. F. E. Mohs* of Madison. Doctor Quisling and his family traveled through the continent following the meeting.

Madison Physician Attends National Heart Meeting

Dr. Chester M. Kurtz, associate professor of medicine at the University of Wisconsin Medical School, attended the twenty-sixth annual meeting of the American Heart Association held in San Francisco June 22–25. Doctor Kurtz is a member of the board of directors of the Wisconsin Heart Association.

Dr. F. J. Davis Joins Madison Clinic Staff

Dr. Frederick J. Davis, until recently a resident physician at the New York Eye and Ear Infirmary, New York, joined the staff of the Davis, Neff, and Duehr Clinic, Madison, in June. The doctor, a son of *Dr. Frederick A. Davis*, Madison, graduated from the University of Wisconsin Medical School in 1946. He interned at the University of Pennsylvania Hospital before beginning his residency.

SOCIETY RECORDS

New Members

James V. Bolger, Jr., Waukesha.

J. C. Swan, Prairie du Sac.

Sidney Jackson, Dodgeville.

J. W. Conklin, Platteville.

C. H. Altshuler, 1300 University Avenue, Madison.

N. A. Mikolajezak, 2002 North 59th Street, Milwaukee.

K. K. Kaufman, Wood.

Henry Horwich, 3321 North Maryland Avenue, Milwaukee.

C. E. Lindemann, 2554 Wauwatosa Avenue, Wauwatosa.

E. G. Olmstead, 2136 South 95th Street, West Allis.

A. J. Ellinger, 1411 Wauwatosa Avenue, Wauwatosa.

A. J. Owens, 152 West Wisconsin Avenue, Milwaukee.

I. L. Slotnik, 4444 East Woodruff Avenue, Milwaukee.

W. F. Krueger, 3525 West North Avenue, Milwaukee.

Changes of Address

L. F. Jenk, Neenah, to 1545 South 27th Street, Milwaukee.

W. B. O'Connor, Marshfield, to 219 Kirkpatrick Building, St. Joseph, Missouri.

Christine Thelan Kilbourne, Madison, to 402 North Jennings Avenue, Anthony, Kansas.

W. D. Battle, Madison, to 1409 H Street, Modesta, California.

E. R. Strauser, Neenah, to Mercy Hospital, Oshkosh.

A. W. Hickey, Green Bay, to La Crosse.

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L. J. Earney, Eugene, Oregon, to Lake Geneva.

A. A. Bullock, Jr., Milwaukee to Wood.

T. S. Rosen, Eau Claire, to Grace Hospital, Northwestern Branch, Detroit, Michigan.

Laird McNeel, Appleton, to Genoa City.

A. A. Drescher, Black River Falls, to Steves Halgren and Long Clinic, Menomonie.

B. J. Haines, La Crosse, to Veterans Administration Hospital, Wood.

Capt. D. B. Becker, Jr., Madison, to 10th Field Hospital, Regensburg, Germany, A.P.O. #225, Care of Postmaster, New York, N. Y.

W. J. Madden, Milwaukee, to 810 South Main Street, Racine.

A. G. Holm, Wood, to 945 North 12th Street, Milwaukee.

C. J. Finn, Wood, to 945 North 12th Street, Milwaukee.

R. H. Schmidt, Jr., Statesan, to 4980 Quebec Street, Spring Valley, Washington, D. C.

MARRIAGE

Dr. Helen Ackerman, Madison, to Herbert E. Stokinger on June 10.

DEATHS

Dr. Orlando P. Schoofs, specialist in diseases of the eye, ear, nose, and throat, died at the Ozaukee Country Club in Milwaukee on June 8. He was 55 years old.

Born in Remsen, Iowa, on July 2, 1894, the doctor attended Marquette University School of Medicine. He received his medical degree in 1916, and, following internship at the Milwaukee County Hospital, took postgraduate studies at the Manhattan Eye and Ear School, New York. His first practice was established in Fond du Lac, where he remained for seven years. In 1927 he moved to Milwaukee, where he served as associate professor of otolaryngology. He was also on the staff of St. Joseph's Hospital.

Doctor Schoofs was a diplomate of the American Board of Otolaryngology and held membership in the American College of Surgeons, the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by his wife and a daughter.

Dr. Arthur C. Nugent, physician at Milwaukee for more than thirty years, died at a Milwaukee hospital on May 27. He was 60 years old.

Born at St. Cloud, Minnesota, on January 12, 1890, the doctor received his medical degree from Loyola University School of Medicine in 1916. He interned at Alexian Brothers and the Chicago Lying-In hospitals. During World War I he served as a captain in the Army Medical Corps. Doctor Nugent was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

A daughter survives.

Dr. L. A. Van Altena, a native of Cedar Grove and a physician there for more than half a century, died at a hospital in Sheboygan on June 8. He was 80 years old.

The doctor was born at Cedar Grove on March 21, 1870. He attended Rush Medical College, Chicago, and the Milwaukee Medical College, receiving his M. D. degree from the latter in 1895. Shortly afterward he became associated in medical practice with his father at Cedar Grove. From 1897 to 1940 he served as village health officer in Cedar Grove, and he was on the staffs of St. Nicholas and Memorial hospitals in Sheboygan.

A member of the Fifty Year Club of the State Medical Society, the doctor held life membership in the Sheboygan County Medical Society, the State Medical Society, and the American Medical Association.

His wife survives.

Dr. Ernest V. Smith, physician at Fond du Lac since 1917, died at his home in that city on June 17. Head of the Wiley–Smith Clinic in Fond du Lac, the doctor was 70 years old.

Doctor Smith was born in Elwood, Indiana, on June 15, 1880. He received his degree in medicine from the University of Minnesota Medical School in 1907, and in 1928 Wabash College conferred upon him the honorary degree of doctor of science. His first practice was established at Adams, Minnesota, and five years later he became a member of the staff of the Mayo Clinic at Rochester, Minnesota. In 1917 he moved to Fond du Lac, where he helped found the Wiley–Smith Clinic.

A fellow in the American College of Surgeons, the doctor held membership in the Association of Resident Physicians and Surgeons of the Mayo Clinic, the Fond du Lac County Medical Society, the State Medical Society, and the American Medical Association. Several years ago he wrote a book entitled "The Making of a Surgeon."

Survivors include his wife, a daughter, and three sons, one of whom is Dr. E. V. Smith, Jr., of Fond du Lac.

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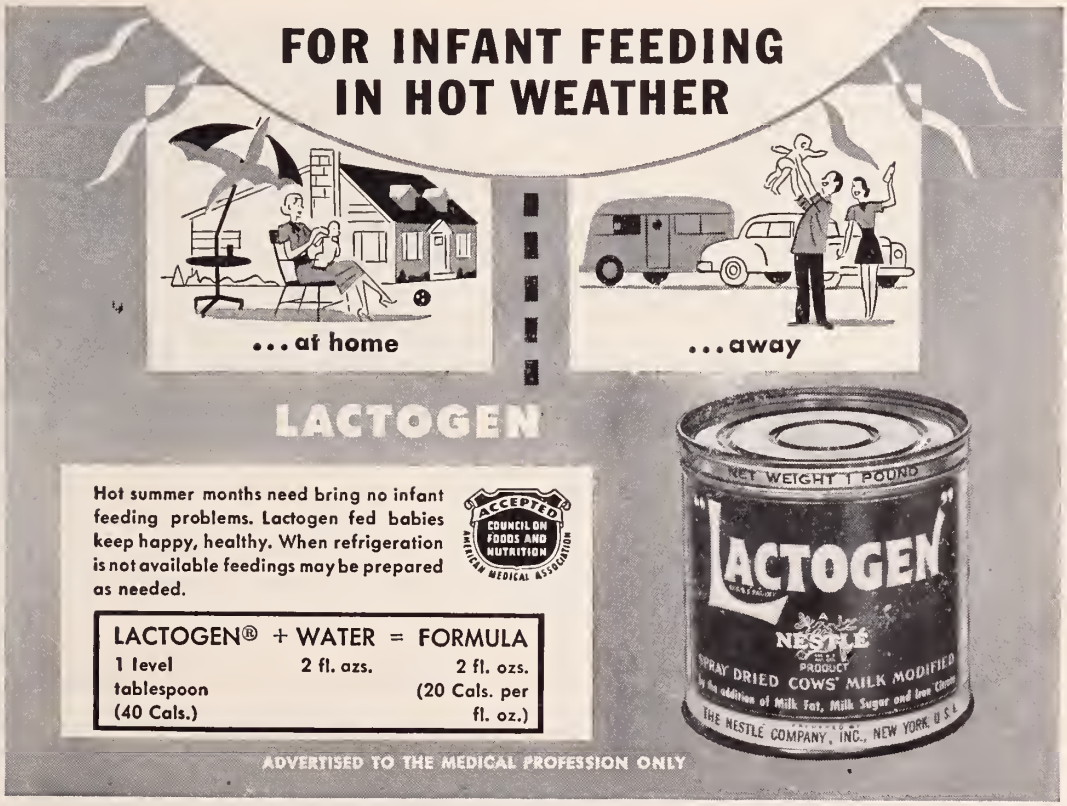

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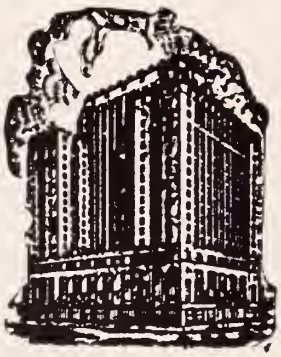

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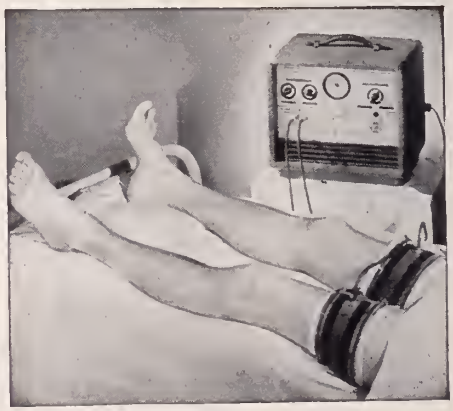

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Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: General electric portable shockproof x-ray unit in excellent condition at ⅓ of list price. One new mobile 30 MA, 96 PKV, Fischer shockproof x-ray unit at $795. One new Fischer short wave with hinged drum electrode and arm, FCC type approved, $355. One used Jones metabolism unit guaranteed accurate at one-half price. One new style Hyfrecator used only a few months, at marked reduction. One used direct writing electrocardiograph at about one-half price, factory reconditioned. C. C. Remington, 720 North Jefferson Street, Milwaukee 2. Telephones Daly 8-6368 and Woodruff 2-4028.

LOCATION WANTED: General practice. Doctor aged 26, married, 18 month internship—1 year general surgery, including urology and orthopedics. Wants to make career of general practice. Address replies to No. 324 in care of the Journal.

FOR SALE: General practice. Owner retiring after 39 years in the same location in northeast Wisconsin community of 3,500. Home, office, and equipment for sale. Good location, good schools and churches. Can easily be made a partnership. Address replies to No. 290 in care of the Journal.

WANTED: EENT man or ophthalmologist capable of doing refractions for association in clinic in busy Wisconsin area. Address replies to No. 300 in care of the Journal.

FOR SALE: Country practice in northwest Wisconsin. No competition. Modern residence, ideally located. Annual dairy income in territory. Nothing to buy but five bed room residence, with office room, waiting room, and laboratory in residence. Separate parking and sidewalk to waiting room. Spacious lawn, foliage, and ideal residence. Young man can use extra rooms for hospital rooms. Selling reason coronary thrombosis. Address replies to No. 170 in care of the Journal.

AVAILABLE: Physician, 35 as locum tenens until December 31, 1950, when begins final year of radiology residency. Background of 3 years' general practice. National Boards. Wisconsin license. Address replies to No. 325 in care of the Journal.

WANTED by well established older F.A.C.S.: A general practitioner for assistant. Married man preferred. Good hospital facilities; salary first six months, then percentage. Apartment available. Suburban area of Twin Cities. Great opportunity for future. Minnesota license or National Boards required. Address replies to No. 303 in care of the Journal.

FOR SALE. Practice and equipment of deceased physician in community of 1,000. Office for rent. Hospital facilities within 15 miles. Address replies to No. 310 in care of the Journal.

FOR RENT: Office of the late Dr. Charles R. Treat, Sharon, Wisconsin. Office fully furnished. Instruments for sale. Call or write to Mrs. Charles R. Treat, Sharon, Wisconsin.

ASSOCIATE WANTED: For general practice in northwest Wisconsin city of 2,500. Dairy farming community 90 miles from Twin Cities. Age up to 35. Especially interested in someone with one or two years' general practice experience or just finishing internship. Address replies to No. 311 in care of the Journal.

WANTED: Assistant to eventually be associate, either E.E.N.T. or E.N.T. State age, experience (need not be full fledged specialist) and stipend expected. Address replies to No. 312 in care of the Journal.

FOR SALE: New AO Projectochart and screen with all slides and AO Lensometer. $500 value, will be sold immediately for $400. Address replies to No. 314 in care of the Journal.

PHYSICIAN'S OFFICE AND EQUIPMENT for rent or sale. Prominent old established location. Retiring from practice. Dr. Bernard Krueger, 3552 East Layton Avenue. Cudahy, Wisconsin.

WANTED: Young physician to locate in village of 500 in immediate future. 1 year free rental for living quarters. Can also finance purchase of expensive equipment if this is desirable. This territory has 1,000 people who are not now serviced by any other doctor within the locality. It is located 6 miles from first class hospital and is within 35 miles of Milwaukee. Address replies to No. 317 in care of the Journal.

PHYSICIAN WANTED: Physician associate with two other doctors in Twin City area of Wisconsin. General practitioner or preferably man with additional obstetric training. Excellent hospital facilities. Address replies to No. 316 in care of the Journal.

AVAILABLE: Experienced general practitioner desires association or independent practice in medium-sized city with hospital facilities. Address replies to No. 315 in care of the Journal.

AVAILABLE: Locum tenens for recent graduate. General practice. Two man clinic, 100 per cent up-to-date set-up in small town. Affords excellent introduction to general practice. Address replies to No. 318 in care of the Journal.

LOCATION WANTED: 40 year old physician would like to do general practice in a city of 5,000 to 15,000. Have ample funds to invest. Prefer city in southern Wisconsin with good hospital facilities. Address replies to No. 319 in care of the Journal.

FOR SALE: Physician's surgical instruments, autoclave, combination operating and OB table, 2 oxygen regulators, examinating and dressing tables, hand drill with chuck attachment, 4 dozen assorted aluminum splints, metal traction bow, etc. Address replies to No. 320 in care of the Journal.

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LOCATION WANTED: Young physician, 25, married, licensed in Wisconsin, recently completed internship, seeking location for general practice in smaller Wisconsin community or position as assistant to busy general practitioner. Address replies to No. 302 in care of the Journal.

AVAILABLE: Columbia Hospital, Milwaukee, Wisconsin has available a one year residency in obstetrics and gynecology to start on August 1, 1950. Salary, $100 per month. Applications are being received now by Mr. J. G. Norby, Administrator.

AVAILABLE: Columbia Hospital, Milwaukee, Wisconsin, desires to secure one general resident to fill an appointment for one or two years to start August 1, 1950. Salary $100 per month. Applications are being received now by Mr. J. G. Norby, Administrator.

FOR SALE: General practice and office equipment in prosperous southern Wisconsin at Brodhead. Excellent hospital facilities available. Only one other physician in active practice. Very reasonably priced but is a real opportunity. Reason for leaving: taking residency. Contact Dr. F. D. Swan, Augustana Hospital, 411 West Dickens, Chicago 14, Illinois.

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AVAILABLE: Internist, Board qualified, age 30, married, completing 3 year residency at large teaching institution. Desire association with individual or group, full time or part time. Will consider buying practice. Wisconsin license. Address replies to No. 322 in care of the Journal.

FOR RENT Small office in a doctor's suite which is very well equipped. Excellent location downtown Milwaukee. Address replies to No. 323 in care of the Journal.

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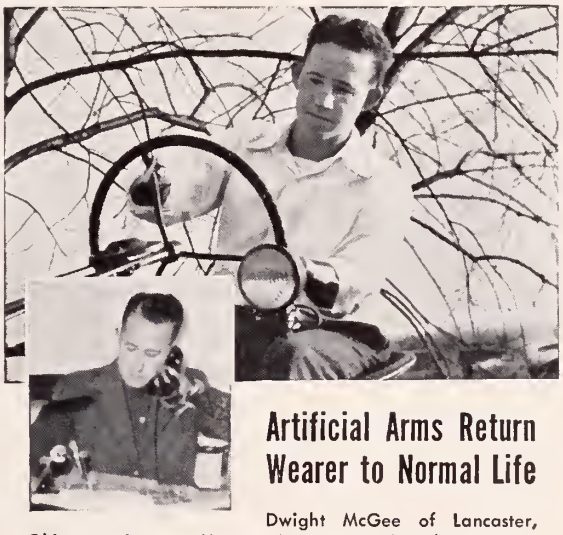

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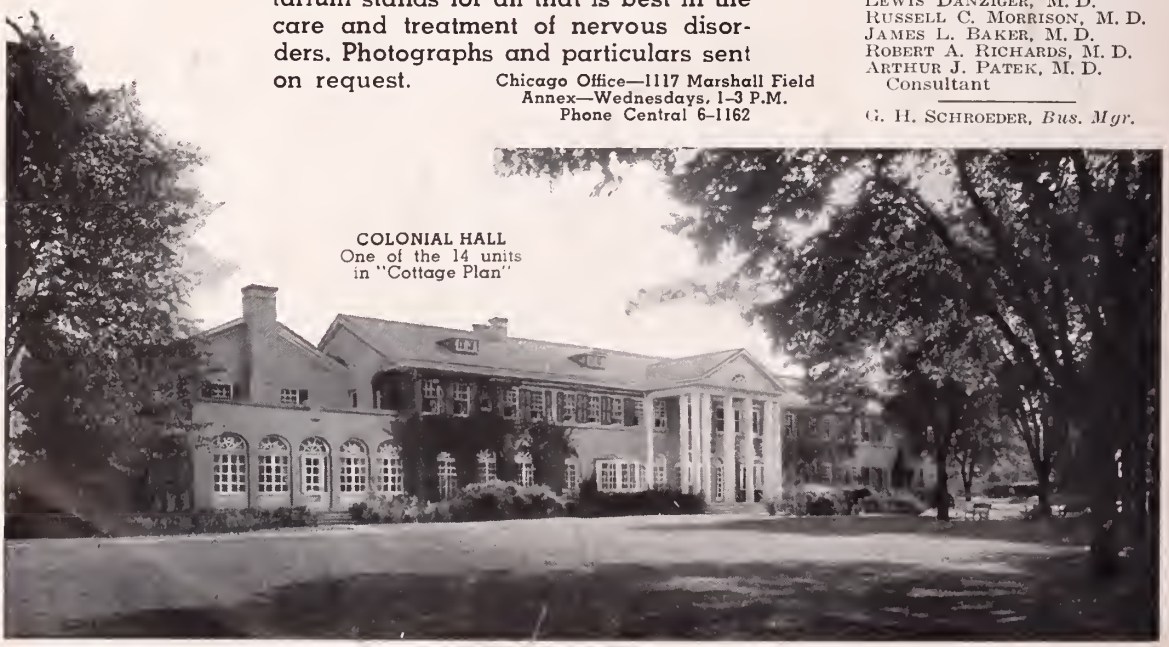

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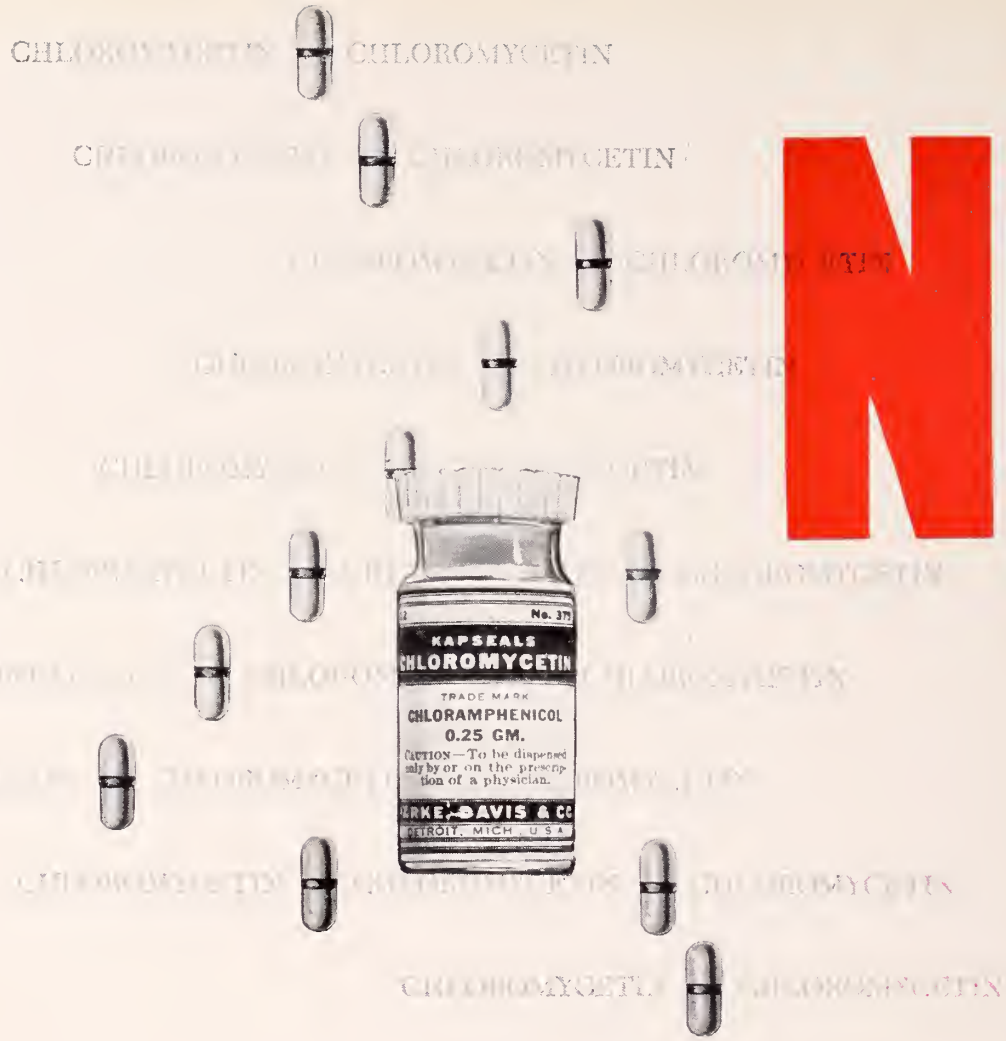

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Payne, E. H.; Knaudt, J. A., and Palacios, S.: J. Trop. Med. & Hyg. *51*:68, 1948

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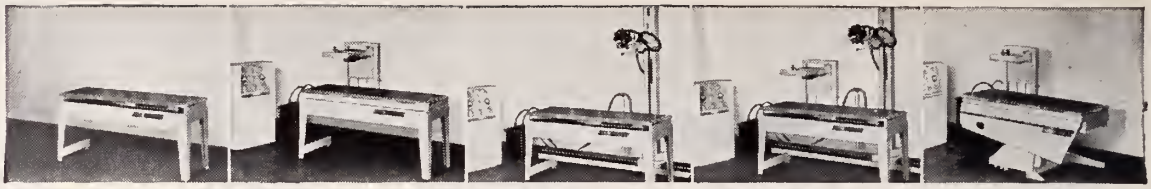

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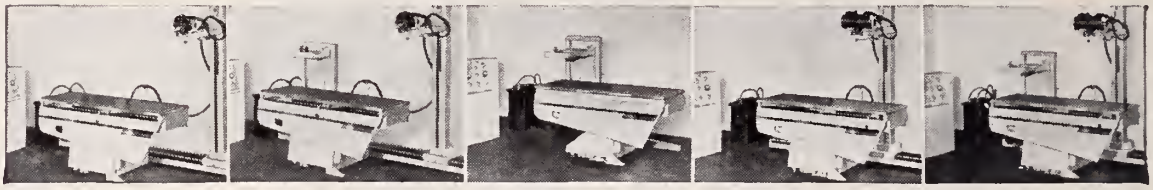

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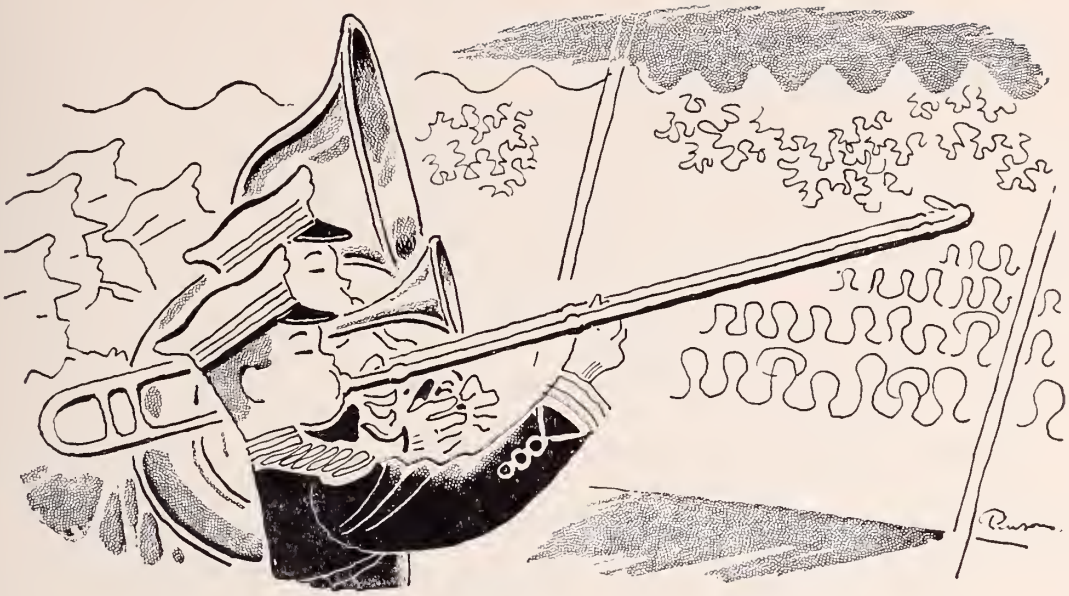

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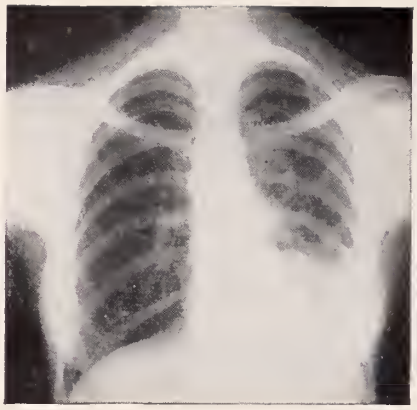

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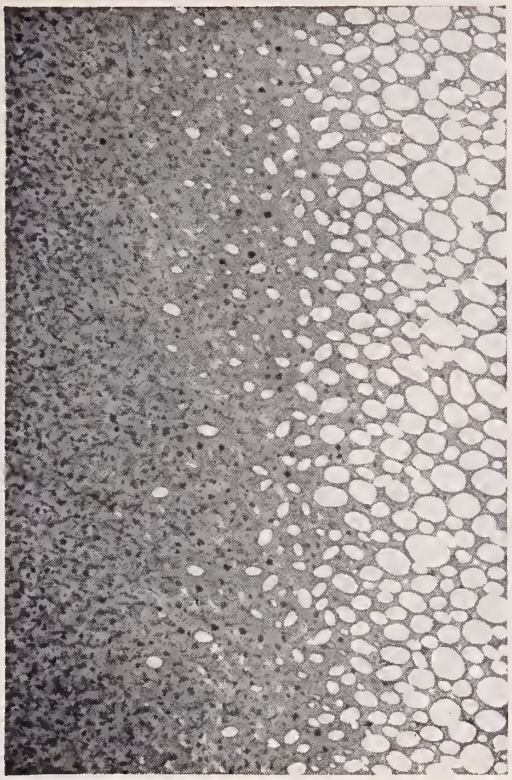

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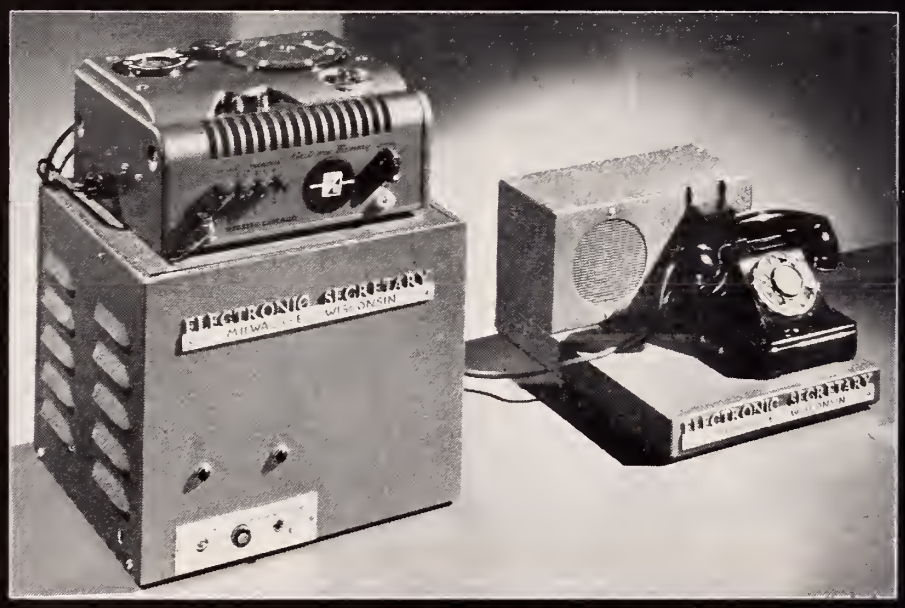

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« « « EDITORIALS » » »

A "Good Buy"

The group disability insurance program sponsored by the State Medical Society of Wisconsin has enrolled a majority of the physicians and will go into effect on August 15, 1950.

The opportunity for enrollment has been extended an additional month, however, for those who have not enrolled to date. All enrollments received on or before September 15, 1950 will be accepted without question as to physical condition. After this date, evidence of insurability will be required for any member who is now eligible. Enrollments should be sent directly to the State Society office. For disability protection this is an excellent buy and one that warrants your immediate and careful study.

To Keep the Lamp Lighted

There is no profession in which continued alertness to change is more essential than in the practice of medicine. The day is long since gone when the acquisition of a diploma and an occasional "refresher course" kept a physician in touch with advances made in his profession. It is said that in the past thirty years more medical progress has been made than in the entire previous history of man. There are those who might question such a sweeping statement, but the fact remains that the physician who wishes to serve his patients with the latest findings in the laboratories and hospitals must seize every possible opportunity to attend postgraduate clinics, participate in scientific programs arranged by neighboring medical schools, and keep up as best he can with his professional reading of specialty journals.

For many years the Council on Scientific Work has attempted to offer members of the State Medical Society a variety of professional experiences through

Society activities. No effort or expense has been spared to make our Annual Meetings of a high professional character. Each year new features are added to provide more and more direct teaching as a part of these programs. Two years ago we incorporated as a part of the scientific program a series of hospital staff conferences. These have been successful, and there is a growing interest in clinic teaching rather than in the didactic method. This year the Council will carry forward the direct teaching program by eliminating lectures from the early part of the day and substituting eight outstanding teaching demonstrations. The variety of the program should meet the needs and desires of every physician. As chairman of the Council on Scientific Work, I urge your careful study of the 1951 Annual Meeting program and your active participation in its many direct teaching features.

The Council on Scientific Work is able to announce the inauguration of an expanded program of postgraduate teaching which ultimately will supplant the traditional "Spring Clinics." The "Spring Clinics" have been highly successful and for that reason the Council terminates them with great reluctance. But it is felt that offering merely an afternoon and evening of lectures is not sufficient to meet the practical needs in this period of rapid progress. Almost at monthly intervals a new drug is introduced, the usefulness of which is modified as clinical experience with it enlarges. For that reason, the Council on Scientific Work has launched a new and more diversified postgraduate teaching program, which will bring a wide variety of clinical knowledge into the area of every physician wherever he practices without necessitating his absence from his community and his patients for successive days or weeks to attend special courses offered in distant teaching centers. For 1951 the proposed program will be conducted in six teaching centers: La Crosse, Eau Claire, and Wausau, serviced this first year by the faculty of the University of Wisconsin Medical School; and Oshkosh, Green Bay, and Marinette-Menominee, serviced by the faculty of Marquette University School of Medicine. If these clinics meet with success as evidenced by attendance of physicians in and around the sites selected, plans call for a shifting of faculties in 1952 and a possible change in sites, particularly on the eastern circuit. It has been suggested that the teaching centers in the eastern part of the state be Fond du Lac, Appleton, and Sheboygan in 1952.

Without your attendance and active interest, this plan will fail to meet the need which the Council on Scientific Work feels exists. The Council is indebted to the State Board of Health for its generous financial support of this program and to the faculties of the two medical schools, who have made themselves available as lecturers and clinical consultants.

It is anticipated that both Marquette University and the University of Wisconsin will expand and further develop their postgraduate teaching, so that those physicians who can leave their communities and practice for three or five days can participate in continuation courses which will provide a variety of teaching and clinical experience.

These are days when medical education is on the defensive. The public has little appreciation of the complexity and cost of the training needed to produce a physician prepared to keep up with medical progress. You and I, as physicians, have acquired training at considerable cost to ourselves—but also considerable cost to the taxpayers of Wisconsin and other states in which we were trained. We are in a very real sense a privileged profession, and our responsibilities to society are great in proportion to our privileges. The greatest responsibility we have, as physicians, is keeping abreast with advances made in our profession. Our alertness to new procedures and new drugs is directly translated into the saving of lives. We owe it to ourselves to keep alert to change; we owe it even more to those we serve.

It has been said that the lamp of knowledge has lighted man's way to a civilized society. If an understanding of physical phenomena and a dispelling of superstitions are marks of civilization, then the light is shining brighter today than at any time in recorded history.

The searching human mind has dispelled superstitions with knowledge; the doctor has applied this knowledge to the recognition, treatment, and control of disease. The professional life of the doctor is based upon an understanding of this knowledge as it advances. Knowledge is not static. The restless, investigating, searching human mind opens new secret chambers to the phenomena of life almost every day and brings to light facts which are applicable to medical practice. Postgraduate study in peripatetic clinics, short courses, and long courses, through reading and observation is an obligation to which every person commits himself who chooses to be a doctor.

The lamp of knowledge is the guiding light of the doctor toward better medicine. Do not lose sight of its luminosity.

Your participation in the proposed clinics for 1951 will encourage the Council on Scientific Work to provide similar experiences in the years to follow. —J. M. Freeman, M. D., *Chairman, Council on Scientific Work.*

Responsibility

The impression which the doctor makes on each of his patients results in the opinion that the public has of him. It is, in other words, his public relations.

The sum total of the impressions which all the doctors make upon all of their patients constitutes public opinion of the doctors. The opinion of the public of doctors is the doctor's public relations. A public relation is not just a confession of faith, it is the act of demonstrating faith; public relation is not just a denial of accusations, it is proof that they are false; public relation is not just newspaper, magazine, and radio publicity, it is the actual performance of duties in the public interest. Denials and professions of faith are recognized as actual only when they are supported by performance.

Because the Alameda County (California) Medical Society has put words into deeds, we print below an editorial from *Northwest Medicine*, Vol. 49, No. 5, May 1950. This editorial describes an example of the finest sort of public relation action.

Current discussion of patients' grievance committees cannot omit reference to the brilliant piece of work done by Alameda County Medical Society in California. This is the smartest public relations program which has come to light so far and represents not merely establishment of a grievance committee but a whole program designed to destroy the socializer's attack right where it lives, in the mind of the public. Alameda County physicians have seriously accepted their responsibility.

They are leaving no doubts in the public mind that they are ready and willing to serve, regardless of finances, time of day, condition of the patient or any other consideration. They have advertised repeatedly, requesting information concerning anyone in that county who believes he cannot get needed medical care because he cannot pay the doctor. Doors of the society office are open to anyone who inquires as to service, who feels he cannot pay standard fees or who has any kind of complaint to make against any members of the profession. They have even provided services of a trained social worker who investigates financial condition of patients when requested and makes suggestions as to fees which can be met without hardship. Such wholehearted willingness to meet the public honestly and sincerely cannot fail to convince every citizen that he can get the finest medical service in the world from a responsible, private system.

First step in this astute program was a research project aimed to find exactly what was wrong with medical public relations in Alameda County. The study revealed three major complaints against the profession. First, that it was often hard for people of small means to get a doctor in emergency; second, that fees charged were so high in many instances that middle class people were less efficiently doctored as a group than the indigent; and, third, that doctors have a union which shields the incompetents and the get-rich-quicks in their ranks. The study was followed by action specifically aimed at the soft spots in public opinion.

First step was a genuine acceptance of the responsibility to provide medical care when and where asked. An attendant was placed on duty at the society office, charged with the duty of obtaining a doctor for anyone, anywhere, anytime. The society virtually guaranteed to provide a doctor when called. This fact was widely advertised to the public.

The problem of ability to pay has been reduced to minor proportions by employment of a trained social worker who can determine accurately the financial ability of the patient and make suggestions or explanations for the benefit of all concerned. The society advises those who are eligible how and where to get services from public institutions.

The medical union myth has been thoroughly exploded by the grievance committee which has even gone so far as to sponsor witness in court against doctors considered to have been unfair in charges for treatment. All complaints are promptly investigated and explained or adjusted to satisfaction of the patient.

The Alameda County Society has done a great deal of work and made some sacrifices. In the long run, however, it has only accepted that responsibility which has always been a part of the real practice of medicine but which has sometimes been less gracefully acknowledged. Public response has been gratifying to those who developed the plan. Most significant was the subhead on an article in *The Nation's Business* for February: *"Socialized Medicine Got a Slap When Alameda, California, Doctors Policed Their Own House."*

COPIES OF SURVEY OF PHYSICIANS BY COUNTY NOW AVAILABLE

A new survey, "Number of Physicians in the United States by County," has been completed by the American Medical Association, and copies of it are available to the medical profession and general public at a cost of $20.00 each. The survey is based on information from the eighteenth edition of the American Medical Directory and subdivides the total number of physicians in the United States into seven counts by county: (1) general practice, (2) practice limited to specialty, (3) special attention to specialty, (4) not in private practice, (5) retired or not in practice, (6) hospital service, and (7) government service. Statistics on the profession are contained in the survey, not the names of physicians.

Copies may be obtained from the Directory Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Some Problems in the Care of Newborn Infants*

By HEYWORTH N. SANFORD, M. D.
Chicago

H. N. SANFORD

A graduate of Rush Medical College, Doctor Sanford served on the staff of the department of pediatrics of that institution from 1928 to 1940. Since 1944 he has been Rush clinical professor of pediatrics at the University of Illinois College of Medicine and is attending pediatrician at Presbyterian and Cook county hospitals, Chicago.

IN THE Chicago area, during the 10 year period from 1936 to 1946, infant mortality was lowered 10 per cent. This saving of infant lives was accomplished principally in the group representing the latter half of the first year of life. Unfortunately, this reduction does not extend into the newborn period. During the same interval of time the mortality for the first two weeks of life was reduced only approximately 3 per cent. This failure to reduce the newborn mortality in the proportions as shown by older infants is reflected similarly throughout the United States and England. Assembled mortality statistics for different areas of the country show that for different areas of the United States and England the newborn mortality varies from 1.82 to 4.8 per cent (table 1), according to Roberts.

TABLE 1.—*Fetal and Neonatal Mortality Studies, From Various Localities, Showing Variations Reported*

	Cincinnati, Assali and Zacharias, 1947	New York, Lebate, 1947	Chicago, Potter, 1944	England, Drillien, 1947
Total Deliveries	15,088	11,669	27,406	7,599
Neonatal Deaths, %	1.82	4.8	2.03	2.68

Obviously, to further reduce infant mortality, it is necessary to have an understanding of its various causes. It will be noted in the table that, while the mortality varies in certain areas and causes of death may differ slightly in total numbers due to different methods of classification, there are four great causes of death of newborn infants. These are, in the following order, prematurity, respiratory difficulties, congenital anomalies, and birth disturbances. These four conditions will account for three-quarters of the total newborn mortality. Of the remaining causes of death in the newborn only infections and hemolytic disease of the newborn are in excess of 2 per cent of the total causes (table 2 from Roberts[1]).

TABLE 2.—*Causes of Death, Showing Similar Variations (in Percentage)*

	Cincinnati, Assali and Zacharias, 1947	New York, Lebate, 1947	Chicago, Potter, 1944	England, Drillien, 1947
Prematurity	49.50	27.6	25.6	19.1
Anoxia	15.78	22.5	28.7	22.1
Intracranial injury	10.70	16.9	13.0	31.0
Congenital anomalies	4.8	7.4	11.1	20.1
Erythroblastosis	----------	1.7	2.5	7.8
Infection	----------	1.4	4.7	----------
Unknown	19.22	0.8	----------	----------

The largest cause of newborn mortality is prematurity. This may, no doubt, be reduced by more conservative prenatal care of the mother and by a better understanding of the obstetrician that the induction of premature labor is a dangerous procedure as far as the life of the child is concerned. If premature labor does occur, however, the chances for life in the newborn infant may be much improved if the baby is either born in or transported to a hospital that is properly equipped for the care of the premature infant.

The essentials of this care consist of first, proper temperature maintenance; second, oxygen; third, proper feeding and proper feeding technic; and fourth, guarding the baby against infection. The Chicago Health Department has promulgated such a plan during the past 10 years. All premature births in Chicago are reported at once to the Health Department, and, if the baby is born in the home or in a hospital not offering adequate premature care, the baby is transported at once in an ambulance constructed for premature infants and containing a heated oxygenated incubator by the City Health Department to one of those hospitals in the city offering care for premature infants. This plan has reduced the premature mortality approximately 10 per cent in Chicago during the last decade.

The second greatest cause of infant mortality is the respiratory difficulties. As many of these deaths are due to anoxia, some reduction in this mortality may be accomplished by proper resuscitation. Table 3, which is taken from Flagg, Little, and Tovell by Roberts, gives the essentials of resuscitation of the newborn. In many instances this consists simply in removal of mucus from the respiratory passages, gentleness always being emphasized, and an atmosphere of oxygen for the first 24 to 48 hours of life.

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

TABLE 3.—*Methods of Resuscitation (from Little, Tovell, and Flagg).*

1. Establishment and maintenance of the airway
   Gentle aspiration of nares, mouth, and pharynx and, when needed, of the trachea and upper bronchial tree
   Aspiration of the supraglottic tract before clamping the cord
   Position of the fetus, 30 degree Trendelenburg
   Stage of flaccidity with collapsed glottic structures and absent reflex demand endotracheal catheter
2. Use of external stimulation; gentleness is stressed
3. Oxygen universally used; method of administration varied; carbon dioxide, controversial
4. Artificial respiration, as
   Mouth to mouth resuscitation
   Endotracheal catheter for suction and administration of oxygen
   Resuscitators of various types
5. Maintenance of warmth
6. Drugs

I would like to call attention to a report of House and Peters on the use of the infant bronchoscope. This is especially helpful in atelectasis involving a single lobe of the lung. Even if only the main bronchus leading to the lobe is cleared, spontaneous drainage will follow in 24 to 48 hours. This condition should always be suspected in all instances of cyanosis of the newborn occurring at once or shortly after birth. It is necessary to rule out other causes of cyanosis, such as congenital heart disease, intracranial hemorrhage, pulmonary infection, tracheobronchial fistula, diaphragmatic hernia, and adrenal hemorrhage. This may be easily accomplished by a roentgenogram of the chest if the fluoroscope indicates a lung density. We have made it a practice to examine all our newborn infants with a fluoroscope immediately after birth and, if such a condition exists, to call a bronchoscopist into consultation at once. It has caused amelioration of the condition in many instances and is not dangerous to the child in any way.

Congenital anomalies, the third greatest cause of newborn mortality, are found most often to be of the heart, nervous system, and gastrointestinal tract. The ones in which some hope of correction may be offered are found most often in the gastrointestinal tract. From a practical clinical point the two chief signs in diagnosis are vomiting and color or absence of the stools. Esophageal vomiting indicating an atresia of the esophagus or a tracheobronchial fistula is an immediate overflowing of saliva, with constant drooling and respiratory difficulty. On the other hand, pyloric or duodenal vomiting due to obstruction at either of these levels of the small intestine is explosive and contains stomach contents only. Obstruction at a still lower level of the gastrointestinal tract, of either the small or the large intestine, may be delayed in its onset but is usually preceded by distention at the point of atresia. Here the vomited material is fecal.

If the obstruction is above the ampulla, the stools will be normal meconium. If it is below the ampulla, they will be gray-white and mucoid. As a final help in such instances, the roentgenogram with or, as is growing more the custom nowadays, without barium or other contrast medium will show gas above the obstruction but none below this point. In the normal newborn infant, air should reach the sigmoid in 7 to 10 hours. Observation of these points will enable us to diagnose the presence and position of the anomaly, and prompt surgical intervention may be life-saving. Needless to say, the newborn infant must be placed in good condition for the surgical procedure by transfusions and adequate water and electrolytic balance.

Intracranial injuries are given as the fourth greatest cause of newborn mortality, but it is very doubtful if these are properly classified. A great many of these infants have other conditions or anomalies of the fetus as the actual background. Fortunately, the old idea that it is always caused by indifferent obstetrics has been abandoned. The diagnosis is not easy, and our present day frequency of autopsies has shown that many that have been given this clinical diagnosis are, in fact, due to some other etiologic factor. I believe that to make the clinical diagnosis it is necessary for the baby to show, first, cyanosis and, second, convulsions and spasticity or flaccidity. Spinal punctures are of doubtful value even in diagnosis, as the finding of red blood cells is not uncommon in the normal newborn infant. The treatment consists of absolute rest, a minimum of handling, elevation of the head, and an easily well digested food. Vitamin K is of doubtful value, although given by many hospitals.

Hemorrhagic disease of the newborn is an uncommon occurrence, although hemorrhagic manifestations are of frequent occurrence in newborn infants. These all subside without treatment of any kind. It is doubtful if the administration of vitamin K has reduced the mortality of this condition at all, and likewise the morbidity. The actual cause of the hemorrhage should be sought, and transfusions of whole blood will cover most of the etiologic factors until the true cause can be determined.

Lastly, infections of the newborn, while not as frequent as formerly because of better nursery technic, still occasionally appear. While there is a variance in their frequency, most reports will estimate them at from 4 to 5 per cent of the total newborn mortality. It is very important to diagnose these at once, as prompt treatment offers a considerable betterment of the prognosis. They should be suspected in every obscure illness during the newborn period. It is often stated that they occur later in the newborn period, but in a study by Silverman and Homan it was found that they occurred 25 per cent in the period of from one to five days of life, 25 per cent in the third day to the seventh, and 20 per cent in the fifth to tenth day of life period. There are three clinical signs that may lead us to suspect the condition. These are (1) temperature of over 101 F., (2) respiratory difficulties, and (3) jaundice. Also, about one-third of them will show gastrointestinal disturbances. Of the above signs, jaundice is the most helpful from a differential basis. Table 4 shows a differential diagnosis of jaundice. If the condition is suspected, to aid diagnosis a blood culture,

TABLE 4.—*Differential Diagnosis of Jaundice in the New Born*

Type	Age of Onset	Skin	Liver and Spleen	Urine	van den Bergh	Icterus Index	Blood
Icterus neonatorum	2–6 days	Golden yellow	0	Urobilin	Indirect	16+	Nucleated red cells not over 5%. Occasional erythroblasts.
Icterus neonatorum precox	2–6 days	Deep yellow	0	Urobilin	Indirect	20+	Nucleated red cells not over 8%. Occasional erythroblasts.
Erythroblastosis fetalis	Birth to 48 hr.	Deep yellow to bronze. May be pallor early or later. Petechiae.	Enlarged	Urobilin Bilirubin	Biphasic	75+	Nucleated red cells 20 to 50%. Many erythroblasts. Myeloblasts. Macrocytic hyperchromic anemia. In 90% infant will be Rh positive, mother Rb negative, father Rb positive.
Nuclear icterus	24 to 48 hr.	Deep yellow	0	Urobilin	Indirect	75+	No change if occurs alone. If with erythroblastosis—like above.
Sepsis	After 4th day unless prenatal	Yellow Petechiae Gross hemorrhage	Enlarged	Normal or urobilin		16+	Nucleated red cells may be over 5%. Anemia develops. Increased white cells.
Winckel's disease	4–12 days	Deep yellow Cyanosis	0	Blood Urobilin	Indirect	75+	Increased white cells. Anemia may develop.
Congenital syphilis	Any time	Varying jaundice Skin lesions	Enlarged	Urobilin Bilirubin	Biphasic	16+	Can simulate erythroblastosis Positive Wassermann-Kahn.
Congenital heart disease	Birth to 14 days	Some jaundice Usually more cyanosis	Enlarged	Urobilin	Indirect	16+	Nucleated red cells can run over 10 percent. Usually normal red count or polycythemia.
Atresia of bile ducts	Birth to 14 days	Jaundice increases to deep green	Enlarged	Bilirubin Clay stools	Direct	100+	Usually no change. May have nucleated red cells over 10%.

umbilical culture, urine culture, and spinal fluid culture should be done.

If the condition is at all suspected, there is no harm in administering some form of chemotherapy immediately, then changing if necessary when the actual organism is cultured. Newborn infants tolerate these very well and rarely if ever show any ill effects from this treatment. Sulfonamides may be given 1 to 2 grains per pound of body weight over a 24 hour period. Penicillin, 20,000 to 50,000 units, may be given subcutaneously every three hours (lately we have been giving crysticillin, 100,000 units daily) or streptomycin may be given, 125,000 units intramuscularly every six hours or 88,000 units by mouth every four hours. Actually the antagonistics to the common organisms affecting the newborn infant are pencillin, sulfadiazine, and streptomycin, against Escherichia coli; penicillin and sulfadiazine against Streptococcus hemolyticus; penicillin and sulfadiazine against staphylococci. Lately we have been giving aureomycin for all of these conditions. This has the added advantage of an ample blood level in oral administration. It is active for both gram-negative and gram-positive organisms as well as for virus infections. It should be given about 25 mg. per kilogram and has the added advantage of giving good blood levels by oral administration.

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Neoplasms of the Blood and Blood-Forming Organs*

By SAMUEL E. KOHN, M. D.
Milwaukee

S. E. KOHN

A graduate of Marquette University School of Medicine, Doctor Kohn served as chief resident at Milwaukee Children's Hospital in 1927 and 1928. Following special studies in Germany, he returned to Marquette as assistant professor of pediatrics. A licentiate of the American Board of Pediatrics, he directs the pediatric department at Mount Sinai Hospital and is on the staff of Milwaukee Children's Hospital.

ACCORDING to the official classification of the Committee on Tumors of the American Academy of Pediatrics, neoplasms of the blood and blood-forming organs should include leukemia, lymphosarcoma, and Hodgkin's disease. Hodgkin's disease is included, even though, by some authorities, it is considered to be a disease of infectious origin.

Although it has been known for many years that neoplasms in childhood result in a high mortality, only recently have they received sufficient attention as a real child health problem.

In a survey of the Department of Health of New York for the years 1942, 1943, and 1944, deaths from neoplastic diseases during childhood exceeded those of tuberculosis. Of these, 45 per cent were due to leukemia and Hodgkin's disease, of which most were due to leukemia.

At the Milwaukee Children's Hospital, for the 10 year period from September 1939 to September 1949, there were 74 cases of leukemia in 46,250 admissions, or 16 cases in each 10,000 admissions. There were 5 cases of lymphosarcoma and 2 cases of Hodgkin's disease.

The border lines between many of the neoplastic diseases of the blood and lymph tissues are not sharply drawn. What appears to be a Hodgkin's disease now may prove, in a few years, to be some other form of malignancy. What could now be a lymphoma, very radiosensitive and apparently curable by x-ray therapy, may prove to be a very x-ray-resistant type of sarcoma in a year or two. It is usually difficult to definitely establish a diagnosis of lymphosarcoma, when it is either accomplished with or followed shortly by a blood cell count suggesting a leukemia.

Not only are there indistinct boundaries between what would be distinct entities and not only are there these transitions from one condition to another, but it is difficult, very often, in border line cases, to determine between lymphomas or leukemias, and some inflammatory processes such as tuberculosis, Boeck's sarcoid and many others.[12]

One must think of these diseases as being in a state of flux, in which the tissues, especially the bone marrow, spleen, lymph nodes and reticuloendothelial symptom, are rapidly or slowly undergoing changes, stimulated or inhibited by various factors, hormonal or otherwise, whose modes of activity are unknown.[12]

I will confine this paper, therefore, primarily to the acute form of leukemia which, as you know, is most prevalent in children.

Leukemia is a fatal systemic disease of unknown causation, in which the normal mechanism for the production of formed blood elements is permanently damaged. It is characterized by widespread proliferation of abnormal cells and their precursors in the circulating blood and their infiltration into various tissues of the body, especially the bone marrow, spleen, liver, kidneys, nervous system, and lymph nodes. Almost invariably, some time during the disease, immature white blood corpuscles appear in the circulating blood. In most cases there is an associated anemia.

Etiology

The most widely held opinion is that leukemia is a malignant neoplasm. Some investigators, especially Cooke, feel that infection plays a dominant role, while dysfunction of the endocrines has also been suggested.

Heredity has been considered to play a dominant role according to Ardashnikov, who lists 31 cases in which other members of the family had leukemia; Decastello, who described 6 cases in one family in two generations; and Hornbaker, who described the condition in 3 sisters.

The disease has also been considered to be congenital in origin and Cross reports 20 such cases. Sex showed a male predominance in the acute and chronic lymphoid types, but no selectivity in the chronic myelogenous groups. No explanation for this male predilection has been suggested.

The various types of leukemias occur at any age, but the acute forms, especially the lymphoblastic, are found most commonly in the first two decades and especially in patients under the age of 5 years. After the second decade, the myeloblastic replaces the lymphoblastic as the common acute form (Cooke).

Classification of leukemia is difficult, inasmuch as the etiologic agent is unknown. It may be based on:

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

I. Clinical progress and then be designated as acute or chronic.

II. According to the presence of leukemic or aleukemic phase in the blood.

III. The parent cell type, such as lymphoblast, myeloblast or monoblast and designated as lymphogenous, myelogenous or monocytic.[13]

While these differentiations are of academic significance, they do not influence the symptomatology or ultimate prognosis of the acute forms of the disease. The manifestations of leukemia are varied and numerous. Since the leukemic cells may invade all the tissues of the body, the symptoms often depend upon the order of their invasion. The first symptoms are general asthenia accompanied by pallor. In a week or two the weakness and anemia often increases, and some manifestations of hemorrhage, such as ecchymosis or bruise spots, or real hemorrhages from the mucous membranes of the nose, gastrointestinal tract, urinary system, or ocular fundus may occur. Anorexia, vomiting, and vague pain in the abdomen or in other parts of the body appear early, and become more severe as the disease progresses. Associated with the gastrointestinal disturbance, there is a loss of weight, sometimes to a point of cachexia. Fever may range from 99 to 103 F. and is of the septic type. In the later stages the child is toxic and lethargic. These fevers are not due to intercurrent infections, as has been suggested, but to the disease itself. This fever may show striking remissions, but even during these remissions a low grade fever remains. Local infections of the skin and mucous membranes are common and often appear early, and may be the first suggestion of the serious underlying disease. Many are deep seated and phlegmanous. Often there are associated ulcerations in the mouth.

Report of Cases

Case 1.—A girl aged 19 months entered the hospital Aug. 22, 1949. She had been confined to another hospital from July 14, 1949 to Aug. 6, 1949, because of a sore throat and difficulty in swallowing. History revealed that she had had bronchitis in December 1948. Her gums had then become swollen and had never completely receded. In April 1949 she had had enlarged cervical glands associated with upper respiratory infection. Since that time she had been irritable and had vomited easily. There was no fever, but she perspired excessively. Cervical glands had remained enlarged for the entire two months.

The blood cell counts in July showed a hemoglobin content of 7 to 9 Gm., red blood cell count of 3,000,000 to 4,000,000 and a white blood cell count from 1,700 to 2,000.

This child was given transfusions and discharged in three weeks.

She entered Milwaukee Children's Hospital because of breaking out of blisters on the skin. The gums about the upper incisors were swollen and bled easily on pressure. The cervical glands were small, but the inguinals were larger. The abdomen was distended, spleen down 6 cm. and the liver 4 cm. below costal margin. There was edema of the hands, feet, lids, and cheeks. Large papulopustular lesions were about the groin, buttocks, and left knee. All were surrounded with an erythematous area and all were indurated. These lesions progressed to a gangrenous state and became more diffuse. She was given blood transfusions and six daily doses of aminopterin of 0.4 mg. each with no appreciable improvement. The child expired Sept. 16, 1949, after 25 days' hospitalization, or approximately four months after the onset.

The temperature had ranged between 99 and 104.5 F. of a septic type.

Blood cell counts showed 2,050 to 4,000 white blood cells with many immature forms. Red blood cells ranged from 3,900,000 before transfusion to 5,000,000 after transfusion, after which there was a subsequent drop.

The hemoglobin was 8 to 10 Gm.

Platelets ranged from 26,000 to 88,000, with many immature forms. X-ray of the long bones showed absorption adjacent to growth zone. There was no sign of periostitis or any bone destruction.

The mediastinal glands were enlarged on the right.

Bone marrow studies showed all forms of immature cells; the diagnosis was myelogenous leukemia.

Dyspnea and palpitation may develop at any stage of the disease and may be present with or without profound anemia or localized mediastinal tumor masses. Lymph node enlargement is a constant but not a striking feature. Usually the node enlargement is a constant but not a striking feature. Usually the nodes are fairly firm and moderately sized, but increase in size as the condition progresses. During remissions they may almost disappear. The anterior cervical groups are usually involved and show visibly, often before the blood picture is evident. The axillary and inguinal groups are moderate in size, inguinals usually smaller.

Enlargement of the mediastinal lymph nodes may produce hoarseness, dyspnea, and a deep brassy cough. Pressure on the return circulation and on the lymph vessels may produce collections of fluid in the pleural and pericardial cavities.

Case 2.—A boy aged 8 years had had a hard dry cough for two weeks prior to his admission at Milwaukee Children's Hospital. There had been no other symptoms until four days before, when he had an upset stomach with anorexia and slight dyspnea on exertion. Examination showed few rales in left base, but the right side of the chest was entirely flat, with absence of breath sounds. Empyema was suspected. Thoracentesis was performed, and 800 cc. of greenish, amber, cloudy sterile fluid was removed. The following day 600 cc. more was removed. X-ray examination after removal of the fluid showed a collapsed lung and a marked widening of the mediastinum. A diagnosis of lymphoma of the mediastinum was made. The blood at this time was normal. X-ray therapy to the chest produced complete absorption of the mass in one month. Approximately two weeks after onset, cervical glands began to swell rapidly. The swelling spread over the scalp. There was no pain or tenderness. The face was slightly edematous and pale. The liver and spleen were not papable. The axillary and inguinal glands were not enlarged. The blood was still normal. During the next month, repeated x-ray treatments were given and repeated thoracenteses performed. The course was progressively downhill. Numerous small hemorrhages occurred, especially in the nose and the kidneys. This boy expired approximately three months after onset of his illness. The blood now showed leukemic changes.

One of the most important signs is the enlargement of the spleen and liver. The enlargement may

be just a few centimeters or extend way down to the pelvic brim. It may disappear during remission only to enlarge later during the active phase. The kidneys, too, may undergo marked enlargement with associated urinary changes, and neurogenic manifestations may appear because of invasion of portions of the nervous system, especially the spinal canal. Since practically any part of the body may be the seat of infiltration with leukemic cells, the symptoms are often determined by the organs involved, and as the disease advances, the symptoms and signs merge into one another, so that the site of the original infiltration cannot be determined.

CASE 3.—A child aged 2 years was first seen one month before admission because of pain in the feet and swelling of the lower leg. Later, the ankle became swollen and discolored. His condition suggested acute rheumatic fever. X-ray showed a mild osteoporosis and questionable slight periostial thickening in the shaft of the left tibia. Large tumor masses were noted in both flanks, not tender but movable. The blood cell count was within normal range although the sedimentation rate was markedly elevated. Approximately two months after the original admission, the child returned for further examination. He had had a persistent low grade fever since discharge from the hospital, with slight swelling in both feet. The masses in the flanks were larger and few inguinal glands began to appear. The blood now showed a leukopenia with a neutropenia. The red blood cell count was 900,000 with the hemoglobin 3.5 Gm. This child expired approximately eight months after the initial rheumatic symptoms and after receiving prolonged treatment in Chicago with a folic acid antagonist.

Laboratory Data

The laboratory is the final word in most blood dyscrasias and especially in leukemia. An increase in leukocytes to approximately 100,000 or over is a most dependable diagnostic feature when associated with a high percentage of "blast" or immature forms. When the leukocyte level is low, as in the subleukemic or aleukemic type, there is usually a sufficient number of immature white blood cells in the circulating blood with associated changes in the bone marrow to suggest a diagnosis of leukemia. The red blood cells are usually reduced in number except very early in the course of the acute type. Anemia may develop so rapidly, however, that it is not unusual to find a count of 1,000,000 or less, shortly after any symptoms appear. All forms of immature red blood cells appear, including reticulocytes and nucleated erythrocytes. The hemoglobin level falls proportionately with the red blood cell level. The platelets usually drop below 75,000. Often spontaneous bleeding occurs. The bleeding time is prolonged from 10 minutes to several hours, but the coagulation time is normal.

X-Ray Findings

Definite bone changes have been described and associated with leukemia. John Dale, in a series of 72 cases, showed osseous changes in 72.5 per cent during some stage of the disease. These osseous changes showed more involvement as the disease progressed and most showed some changes in the knee area.

The significant roentenographic changes noted were (1) transverse bands of diminished density in the metaphyses of the long bones immediately adjacent to the epiphyseal plate; (2) osteolysis; (3) periosteal elevation and new bone formation; and (4) osteosclerosis.

None of these findings are absolutely conclusive, and have been demonstrated in other conditions, but they are suggestive in the presence of clinical or hematologic signs of the disease.

Course and Treatment

Many kinds of therapy have been suggested for leukemia and excite considerable enthusiasm for a short time. The essential elements of treatment have been to make the child as comfortable as possible. In the presence of severe anemia and hemorrhage, transfusions may relieve the marked distress for a short period. X-ray therapy often makes the patient more comfortable, especially when there is marked lymphoid enlargement, with enlargement of the liver and spleen. It is not as effective in acute as in chronic leukemia, and it should not be used in the leukopenic phase, as it may produce a marked anemia.

Arsenic has had almost no effect on acute leukemia.

Radium and radioisotopes have shown some beneficial effects, especially in chronic forms, but mostly in making the patient comfortable and for lengthening the periods of remission.

Mustard nitrogens have shown no appreciable effect in acute leukemia.

Urethane (ethyl carbamate), which is supposed to arrest mutation or mitosis in cell development, has shown to be of no help in acute leukemia.

The most recent form of therapy is the introduction of a group of folic acid antagonists, of which aminopterin shows the most promise (Meyer, Fink and associates). These drugs have produced temporary remissions in the course of acute leukemia in children, as reported by Meyer and Fink,[1] Sidney Farber,[2] Farber and Diamond,[3] and in adults as reported by Dameshek.[4] By antagonist to folic acid is meant a substance which possesses the property of inhibiting the growth of Streptococcus fecalis or Lactobacillus casei in marginal levels of folic acid. Reversal of inhibition occurs when the concentration of folic acid in the culture medium is elevated. Aminopterin, the most recent, is chemically "4-aminopteroyl glutamic acid". It is given in daily doses intramuscularly. The pattern of therapy is not definitely established, and almost daily blood cell counts must be made to watch for the very rapid drop in the white cell counts that occur. Emperically, doses of 0.25 to 1.0 mg. can be given daily. There is little or no effect on the platelets or on the anemia. Immature forms may disappear, but the major change is in the total white blood cell count which becomes leukopenic. Toxic manifestations which accompany the use of aminopterin are severe and distressing. Severe irreversible hypoplasia of

the marrow is to be watched for. Other toxic manifestations are (1) ulcerations of the buccal and pharyngeal mucous membrane with the formation of dirty, gray, overlying membranes on an erythematous base; (2) atrophic changes in the intestinal epithelium associated with gastrointestinal hemorrhage, hematemesis, and rectal bleeding; (3) alopecia; and (4) maculopapular hemorrhagic skin eruption.

Conclusion

Leukemias of infancy and childhood are more widespread than previously believed. The bizarre picture of the early condition sometimes makes it difficult to arrive at a definite diagnosis. If such a diagnosis can be made early enough, the child can be made much more comfortable during the course of his disease. Unfortunately, no cure has as yet been advanced. Probably the new folic acid antagonists may hold some promise.

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WISCONSIN ASSOCIATION FOR PUBLIC HEALTH TO MEET IN MADISON

The Memorial Union on the University of Wisconsin campus in Madison will be the headquarters of the two day annual meeting of the Wisconsin Association for Public Health, September 11 and 12. Dr. Charles K. Kincaid, Madison city health officer, program chairman, has announced the general theme of the meeting as "Public Relations—Why Bother?" Dr. Stephen E. Gavin, Fond du Lac, president of the State Board of Health, will give the welcoming address. Arthur H. Brayton, of the Des Moines chamber of commerce, will give the banquet address on Monday evening, September 11.

A new feature of the meeting will be a series of dramatized life situations in the office and field by public health nurses, engineers, sanitarians, health officers, and secretaries under the professional direction of Mr. Raymond J. Stanley, production manager of radio station WHA in Madison.

The general registration fee for both members and non-members will be $1.00.

RESEARCH FELLOWSHIP PROGRAMS ESTABLISHED BY ARTHRITIS AND RHEUMATISM FOUNDATION

The Arithritis and Rheumatism Foundation is offering fellowships for research in the basic sciences related to the study of arthritis. These fellowships carry a stipend of from $4,000 to $6,000, depending upon the needs and ability of the worker, and run for a period of one year. The fellowships would begin in July 1951, although earlier appointments would be considered by the committee.

The Foundation is anxious to back a candidate, rather than a project, an institution, or a hospital. It hopes to arouse interest in arthritis in a wider circle of medical investigators and to encourage able, inquiring minds.

Applications should be sent to the Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, New York by January 1, 1951. Notification of the fellowships granted will be made March 1, 1951.

If any applications are received by September 15, 1950, they will be acted on at that time and notification made immediately.

Emotional Problems of Children*

By GILBERT J. RICH, PH.D., M. D.
Roanoke, Va.

G. J. RICH

Doctor Rich obtained a Ph.D. in psychology from Cornell University, and following several years of teaching in this field, he received his medical degree from Rush Medical College. From 1933 to early in 1950 he was the director of the Milwaukee County Guidance Clinic. At present he is directing the Roanoke Guidance Center at Roanoke, Virginia.

THOSE of us who are working in the field of mental and emotional difficulties cannot help being pleased by the growing interest of medical men in psychiatric problems.

Psychiatric knowledge has made it plain that people show their emotional difficulties indirectly rather than directly. This statement is true of adults. It is even more clearly evident in the case of children. They have greater need of indirect expressions of their emotional troubles than do grown-ups, because they have less facility in expressing them verbally and also because in many cases the punitive attitudes of their elders make them fear to talk freely about their feelings. In general, there are two common methods of emotional expression in children. They do not represent essentially different mechanisms, and the distinction between them is purely one of convenience. One type of expression is through changes in the bodily economy. The various types of disorders and complaints dealt with in psychosomatic medicine are essentially emotional expressions. I shall not consider them because they are to be dealt with in the following paper by Doctor Jensen. The other means of expression is in overt behavior. The various behavior problems of children are, like the psychosomatic disorders, ways in which the younsters express their feelings. Unfortunately, these feelings are usually not understood as such by the parents. Many of these patients with behavior difficulties come to the physician for help. It would seem that we should be ready to give aid to the families for this type of emotional expression as readily as for the psychosomatic type.

The factors which cause emotional difficulties in children are many and varied. By and large, they stem from the frustration of children's needs. Frustration of one's needs is, of course, an essential part of human life. As biologic organisms, we are not fitted to live together in modern civilization. Each of us has to learn how to curb his own desires so that he can be a social being. Children must be taught this, and in so doing they are subjected to a great deal of frustration. We may well ask how one can avoid creating problems in children if frustration is, thus, inevitable as a part of growth. The answer is to be found in the fact that the tolerance of the child for frustration of his needs and desires is something that grows and develops with life. If the child is subjected to frustration in too severe a form or at too early an age, so that he is unable to tolerate the deprivation, deep emotional problems result.

It would be well to call attention at this time more especially to those needs which suffer frustration most frequently. First of all, we must note that a child needs love. This is normally received from the parents. We would be making a severe error if we were to suppose that the giving of love by the parents is a universal phenomenon. Such is not the case. There is in our American culture a very high ideal of parental love. This sometimes blinds us to the fact that the mere physical act of being a parent does not necessarily mean that the father or mother loves the child. Those of us who are doing clinical work with problem children see very many cases in which there is rejection of the children by the parents rather than any true love of them.

There are numerous possible causes of parental rejection. In many cases the reasons are essentially selfish in nature. One or both parents does not wish to give up any of his pleasures for the sake of the child. This may take the form of resenting the cost of having or rearing the child, feeling hurt by the necessary deprivation of activities because the parent has to stay home and care for the child, hatred of the additional work that is involved in bringing up the child, etc. On the other hand, rejection may be based upon the circumstances of birth, such as its occurrence at an unfortunate time in the life of the parent or the forcing by the birth of the child of a marriage which turns out unhappily. We also see parental rejection based upon one parent's identifying the child with the other parent with whom he or she is unhappy. Moreover, one must recognize that the rejecting parent is himself or herself faced with a conflict between his or her own feelings and demands that society puts upon him or her to be a good parent. Relatively few fathers and mothers can face the fact of rejection. Most of them conceal it from themselves either by blaming it upon the child's behavior or else by indulging in

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some type of compensation, usually over-protective in nature.

One must also remember that children need to grow up. Indeed, insofar as childhood is thought of as a period of preparation for later life, one must see that the chief task of the child is to grow up. Psychologically, growing up is a process in which the child becomes less and less dependent upon others (particularly the parents) and more and more dependent upon himself. Parents often prevent children from growing up either by abnormal strictness or by taking an overprotective attitude. Parental overprotection can be understood as compensatory behavior upon the part of the parent, compensating either for deep rejection of the child or for some lack in the parent's own life.

The growing child feels a need to accomplish something. Often circumstances are such that the child is not able to do anything well. This may be due to causes inherent in the child himself, such as actual physical or mental inferiorities. More frequently, it is due to attitudes of the people around the child, who fail to provide him with any situations in which he may do something successfully. It is surprising to note the extent to which parents and schools are zealous to see how little satisfaction children can obtain from life.

This discussion of parental attitudes should not in any sense blind us to the fact that there are many other influences in the child's life which may cause frustration. The parents are seen as most important simply because they form the most prominent part of the child's environment during the very impressionable and formative early years of life. The rivalries which occur between brothers and sisters play a very considerable part in shaping emotional drives. As the child becomes older, his response to and treatment by his companions plays an increasingly important role in his life. A little later, the child goes to school. There he has to meet competition with other children, good and bad attitudes of teachers, etc. All of these are likely to produce frustrations and to give rise to emotional difficulties.

It is possible at this time to mention only a few of the commoner behavior problems which are brought to the attention of physicians. Probably one of the most frequent is a refusal of the child to eat. We must realize that food is for many children a symbol of parental love. When the child refuses to eat, he is accomplishing something that is of value to him. He gets the parent to urge him to eat and he thereby makes the parent show this symbol of his love. Of course, the refusal of food may mean other things, such as a means of gaining attention from the parents or a weapon to use against them. In any event, the value of not eating to the child is always a result of the parental attitude toward it. It is worth while for the child to refuse food only if the parent is thereby incited to some form of action, whether it be urging, anger, punishment, etc.

It must follow from this that treatment of the situation lies primarily in removing the taking of food (or the failure to do so) from the sphere of emotional expression. Inasmuch as the parents, by their response, have made the refusal useful to the child as a means of expressing his feelings, it must follow that this value of food can be eliminated if the parents will cease to be concerned as to whether the child eats or does not. Naturally, the physician may be faced with the problem of balancing the physical and the emotional needs of the child. He will have to ask himself whether the harm done by allowing the child to go without food, even to the extent of not eating at all for a few days, is greater or less than the good done by treating the behavior and abolishing it as a source of friction within the home. It is only the rare case in which the physical factors are so important that the parent cannot be advised to ignore whether the child eats or does not eat. Experience has shown that the task of teaching parents how to handle these situations is not an easy one. General instructions are apparently ineffective. The parents must be given very specific directions as to how to handle each situation in the light of the new attitudes which they are now to assume. Moreover, one cannot be sure that the parents will be able to understand and accept purely intellectual treatment of the situation. It must be remembered that it is their own emotional needs which have caused them to adopt the unfortunate attitude toward the child's food, and these emotional needs will often require some attention at the hands of the doctor.

Another common behavior problem of children is the existence of temper tantrums. These vary all the way from expressions of anger to assaults upon the parents, destructiveness toward the home and its furnishings, and even mild attempts on the part of the child in the direction of self-destruction. A temper tantrum has very much the same function in the child's emotional life as does refusal to eat. It is a means by which he or she can accomplish something that he wants, even if that something is no more than attaining the attention which the parent has to give when he spanks or otherwise punishes the child. In this connection, it should be noted that there is no justification for assuming that punishment always deters or that a child will always behave so as to avoid being punished. On the contrary, we see in the child guidance clinics many children who actively seek punishment either as a vicarious solution for feelings of guilt or because they wish the attention of their elders to so great an extent that they would rather be punished than ignored. The display of temper may also be a means of fighting against the parent when there is a poor personal relationship between the parent and child. The cure of temper tantrums is as simple as that of refusal to eat. The significance of the temper tantrum is given to it by the parental reaction, and, when the parents stop responding, the child is no longer able to accomplish what he desires. Occasionally, of course, we see a child who has

temper tantrums because of excessive irritability which is on an organic basis. These cases are particularly marked by the impulsive nature of the child's outbursts, which often occur without any adequate reason. In such cases (and they are relatively rare), it might be well to look for a history of some illness which might have had encephalitic components and to either confirm or rule out their existence by means of an electroencephalographic tracing. In most cases of organically determined abnormal behavior in children, the brain injury is so minor in extent that the neurologic examination is negative, but the abnormality is often noted by means of the electroencephalogram.

Allied to temper tantrums is the problem of disobedience. This is a term which has varied meanings to different people. We see it running all the way from a child's normal trend to depend upon himself to a real negativism. In most cases, the causative factors are to be found in the attitudes of those who are dealing with the child rather than in the child himself. This means that it is necessary to handle the cause rather than the symptom and that no single method of treatment can even be suggested. What is usually needed is essentially a complete reorientation of the parents or school in methods of dealing with the particular child.

A much more difficult problem to deal with than any of the above is enuresis. One reason for this is that it is so closely interwoven with one of the major early frustrations of a child, that of toilet training. No doubt, we often fail to recognize the extent to which we are frustrating an infant when we cause him to give up the freedom of eliminating waste products when and as he pleases and require him to fit into the pattern which our culture sets. Toilet training illustrates the previously emphasized point that a child cannot safely be frustrated until he has developed to the point where he can tolerate that frustration. A few years ago, it was fashionable in medical circles to advise mothers to toilet train their children at ages as early as those of 6 or 8 months. This advice was eagerly accepted by the mothers because it brought them an early relief from the drudgery of washing diapers. Today, we are seeing many older children with marked negativism and hostility in whom we have obtained histories of toilet training prior to 1 year of age. They are expressing in their later life the hostility engendered by this frustration at a time when they were not sufficiently mature to tolerate it. Fortunately, the pendulum has swung in the other direction. Medical men are no longer advising parents to toilet train their children at such early ages. Indeed, the pendulum has sometimes swung too far and advice has been given against any toilet training so that the child reaches a fairly mature age without learning the necessity of becoming socially acceptable. It would appear that the second year of life, that is, between the ages of 1 and 2, is the optimum time for developing daytime habits of elimination and that the third year of life is the optimum time for extending these habits throughout the night. Many children are trained before the age of 2 to be dry both day and night without any harm, but there would hardly seem to be any justification for calling the child enuretic because it wets the bed at the age of 2. It is only after the third birthday is past that it can be considered a serious problem. In addition, we must realize that bed-wetting, because it brings forth a reaction from the parents, can serve the child in the same ways as do temper tantrums or refusal to eat. Finally, we must also recognize that any type of activity involving the genitourinary system in this way becomes linked with sex and may become an expression of a sexual conflict.

The handling of the enuretic child presents many difficulties. Certainly, the first thing to do is to minimize the tensions within the home situation. This involves having the parents cease all shaming, punishments, and threats connected with enuresis. A second step is to arouse in the child not merely an interest in being dry, but a feeling of success. This can be accomplished by a regular program of awakening the child at night, arranging the time or times of awakening so that the child will be successful in keeping a dry bed. It does not matter that this success has been accomplished primarily through the efforts of the parent who has to get up at night and do the awakening. The important thing is that the child shall have the feeling of succeeding in being dry. We wish to build self-confidence. It is my feeling that the time-honored treatment of eliminating the intake of fluid after 4 o'clock in the afternoon is at best only a weak supplement to other forms of treatment. It is very seldom that it effects a cure by itself.

The few problems mentioned here are merely examples of how children use their behavior to express themselves and to find outlets for their emotional problems. The situations involved are usually quite complicated, both because the child is subjected to a myriad of factors influencing his feelings and behavior and because he has many ways of self-expression. It is hoped that these few examples will emphasize the importance of thinking of a child's behavior not in terms of what it means to the grown-ups in his environment, but rather in terms of the child's own needs and the means he is using to satisfy them.

ATTENTION: ALUMNI OF WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

Plan to attend the first alumni reunion stag dinner of Washington University School of Medicine, St. Louis, at the University Club of Milwaukee on Monday, October 2. No formal program has been planned. Reservations may be made with Dr. J. P. Conway, 1800 East Capitol Drive, Milwaukee, Wisconsin.

Emotional Problems in Children, With Emphasis on Implications in Medical Practice*

By REYNOLD A. JENSEN, M. D.
Minneapolis

R. A. JENSEN

Doctor Jensen, a graduate of the University of Minnesota Medical School served as a director of youth activities in Milwaukee before obtaining his M.D. degree. After internship and three years of graduate training in psychiatry, he joined the faculty of the University of Minnesota in 1938. He is now an associate professor of pediatrics and psychiatry and is in charge of the child psychiatry program at that institution.

ONE current trend in the field of medicine is an expanding interest in factors other than infection, trauma, or processes of deterioration which may be of etiologic significance in the complaints presented by our patients.

Largely as a result of steady persistent clinical and experimental studies of situational factors and their concomitant emotional reactions and the experiences both in the armed forces and in the civilian populations during the last war, a gradual acceptance of the importance of emotional tension inherent in the problems presented to us is developing. Various estimates have been made as to the extent of the problem. Most students of the field agree that approximately one-half of all patients, young or old, consulting a physician have no demonstrable evidence of physical disease to explain their complaints.

While the majority of studies reported thus far have been confined largely to the adults, they often reveal the roots of later difficulties in earlier life. Studies of children in this area further emphasize the importance exaggerated tension has in the individual during the process of maturation when basic patterns of thinking and feeling are developing.

This is not surprising, for from the moment of birth, the infant, in his state of almost complete dependency, requires the help of others in the satisfaction of his total needs. All living is in relation to others. Successful living, particularly during the early years, depends upon the orientation and understanding of the parents, more particularly the mother upon whom the child is most dependent. Parental appreciation of the struggles involved as the child learns to differentiate himself as an individual and to define his relationship to others smooths the way for the assumption of responsibility commensurate with successive stages of development. When such a situation obtains, the child moves quite easily and comfortably from one stage of development to another. However, when parents lack an appreciation of the struggles inherent in the process of maturation, and the child's total needs are not reasonably well satisfied, difficulties develop.

Whenever excessive tension develops, from whatever the source, the child has difficulties which may assume many different forms. Doctor Rich, in the preceding paper, has clearly delineated some of the causes for tension developing and indicated ways in which the child may manifest his difficulties by presenting adjustment problems of behavior. With your permission, I should like to briefly suggest high lights of some of our experiences in dealing with sick children in a large, busy hospital.

Because of the interest we have had in the possible role which disturbed feelings (emotional and psychologic factors) may have in the pathogenesis of pediatric disorders, we have worked psychiatrically with many children and their families. A few of our findings and impressions are presented for your consideration.

Three areas have been of interest to us: (1) children who present symptoms of illness which are directly related to disturbed emotional states, (2) children whose physical illness is complicated by disturbing emotional factors and, (3) children with physical illness, the causation of which is obscure.

Because of the limitations of time, it is possible to present only one patient situation in illustration for each group mentioned.

Group 1

Jane, aged 7, was admitted to the University of Minnesota Hospitals with all the classic clinical symptoms of renal colic, which is not a common complaint encountered in pediatric practice, though it does occur. However, general physical and laboratory studies, including roentgenographic studies, were entirely negative. Because her symptoms persisted, she seemed to be quite undisturbed by them, and as no complaints were noted during the night hours, we carefully explored the possibility of exaggerated emotional tension as an important factor in her illness.

Our study revealed that the family was composed of eight children (the patient was the fifth in line) and the mother. The father was confined to a major correctional institution not only for abusing his family but for attempting to injure them seriously. While life had been hectic for the entire family prior to the father's confinement, it had been happy

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

and complacent since his leaving the house. The family lived in a house located in a semi-isolated place in the country.

Immediately prior to the onset of our patient's illness, two disturbing circumstances occurred. The family had received news that the father was seeking parole privileges, and, quite coincident to this, a strange car had cruised back and forth on the country road in front of the home. On one or two occasions it had stopped for varying lengths of time within view of the home.

Immediately the family was alerted and very much on guard. No one ventured out alone. At night the dogs were brought indoors and the windows and doors were barricaded, with one member of the household awake all the time.

It was at the height of this turmoil that there suddenly developed in our patient the symptoms which brought her to the hospital. In the course of our investigations, we learned that our patient had been a particular object of attack by the father.

With this information, we worked carefully with the patient, who readily told us of her intense fear of her father and what he might do to her. The extent and degree of her fears are quite clearly demonstrated by the fact she dreamed every night "a ghost is standing over my bed." The ghost subsequently turned out to be her father. As she related her fears to us, her improvement was steady and rapid. She left the hospital well.

The question regarding her "choice" of symptoms, we believe, is explained by the fact that shortly before her illness her grandmother, to whom she was devoted, had had an attack of severe renal colic.

In our opinion the absence of any confirmatory findings of true renal colic, the hectic turmoil of the home described, and the patient's prompt response to simple psychotherapeutic measures justify the diagnosis of conversion hysteria.

The fact that children can suffer from psychiatric disorders is often overlooked. When omitted from consideration in differential diagnosis, the problem tends to persist and often becomes progressively severe.

The psychiatric conditions commonly encountered in children are the anxiety states, excessive fears and phobias, anxiety and conversion hysterias, the obsessive-compulsive disorders and hypochondric states. In every instance, excessive emotional tension is fundamental in the pathogenesis of the disorder.

Group 2

The case of John, aged 11, illustrates our experience in the second group of cases.

John was transferred to our hospital for treatment of second degree burns of extensive proportions because he had shown poor response to therapy in the local hospital. Response to our efforts was no different from his previous placement. He was difficult to manage, irritable, demanding and at times unpredictable.

Careful study of his situation revealed he had been over-indulged by his family, particularly his mother. Despite strained economic circumstances of the family, the mother made frequent trips to the hospital to visit him. She also sent many letters and postcards. In every way she seemed to be a most concerned mother.

Our cue to the basic difficulty came on a day following a visit John had had with a friend. In an outburst of temper he exploded "she's just like my mother. She promised to visit me today and she didn't come." Careful inquiry with John revealed that he was bitterly disappointed by a series of broken promises from his mother. Following each visit he had been reassured by his mother that she would visit again the following day, only to be disappointed. He was seriously disturbed to the point of rebellion by such treatment.

On the mother's next visit, the situation was thoroughly discussed with her, and she, fortunately, saw for the first time what had been happening. With the understanding gained from our interview, she clarified the situation with John. With confidences renewed, he settled down and soon became a most tractable lad. Coincident with this, his burns began healing.

In our experience, we have found attendant emotional problems complicating the illness of children suffering from convulsive disorder, allergies, diabetes and other chronic conditions. While it is true, the easing of emotional tensions does not result in complete amelioration of the disorder, its severity is substantially reduced often to the point of becoming negligible when attention is accorded them.

Group 3

With regard to the third group of individuals who are physically ill but have no definite etiologic agent to be demonstrated, let me briefly cite the case of Andy, who was admitted to our hospital because of persistent bloody stools. A diagnosis of ulcerative colitis was made in his case.

Repeated physical studies, including meticulous analysis of the stool, proved to be negative. At the time of admission to our hospital he had been ill for one year. He was badly emaciated, anemic, thoroughly discouraged, and a very stubborn lad to work with. Appetite was poor. Frequent stooling added to his concern.

Careful inquiry into his past history revealed him to have been a happy, energetic lad who was generally accepted as a leader in his group. The onset of his illness was sudden, occurring within the short space of one week.

Analysis of the circumstances existing during the week that his illness began revealed that he had witnessed a robbery with shooting, resulting in the death of a store keeper. As the only material witness in this event, he was interviewed many times by the police. He also visited headquarters often to view suspects and, in general, was under considerable emotional tension. The onset of his diarrhea occurred the day his name and address appeared in the local paper!

It was further of interest to us that he had never been known to discuss his own feelings about the case with anyone. It was an extremely difficult task to encourage him to do so. In fact, we were never successful until after a prolonged period of care and extensive treatment, both medical and surgical, which included an ileostomy followed by a colectomy. After these major procedures, we did finally get a full story of his reactions to the traumatic episode.

In our experience many similar circumstances have been encountered. The majority of these seem to center in conditions of the gastrointestinal tract, such as unexplained abdominal pains, nausea with vomiting for which no explanation could be found, progressive weight loss due to anorexia nervosa,

excessive eating with or without obesity, and constipation. Other conditions, such as hyperthyroidism in adolescents and certain dermatologic conditions, have been studied. In many such instances, excessive emotional tension has been found present. The recognition of these and effort to ameliorate them have resulted in encouraging improvement and in some instances recovery.

As a result of over ten years intimate association with an active pediatric service of a large teaching hospital, it is our impression that emotional tension is often of etiologic significance in the complaints offered by children. When recognized and dealt with early by simple procedures, the resolution or amelioration of the tension state has contributed significantly not only toward understanding the problem presented but also in many instances, toward materially helping in assisting the patients to recovery.

The acceptance of the importance of emotional tension as a contributory etiologic factor in the pathogenesis of pediatric disorders, a willingness to explore the areas from which tension may arise, and the offering of help toward its resolution by every physician working with children will do much toward not only preventing more serious difficulties from developing, but also helping sick children speed convalescence.

WISCONSIN SOCIETY FOR MENTAL HEALTH TO SPONSOR CONFERENCE

The third statewide mental health conference sponsored by the Wisconsin Society for Mental Health will be held on Friday, September 15, at the Hotel Schroeder, Milwaukee.

Dr. Leslie A. Osborn, recently appointed director of the division of mental hygiene, State Department of Public Welfare, will be the guest of honor and the speaker at the President's Dinner on Friday evening. Frederick DelliQuadri, director of the Division of Child Welfare and Youth Service, will tell of Wisconsin children and youth and their tomorrow. George S. Siudy, pastor of the First Congregational Church in Minneapolis and president of the Minnesota Society for Mental Hygiene, with a wide range of mental health service experiences, will be the keynoter for the conference Friday morning.

Further details may be obtained by writing to the Wisconsin Society for Mental Health, 405 East Grand Avenue, Beloit, Wisconsin.

MADISON CHAPTER TO BE HOST TO STATE ORGANIZATION OF GENERAL PRACTITIONERS

The Wisconsin Chapter of the American Academy of General Practice has announced that its second annual convention will be held in Madison on Wednesday, November 8.

The Madison Area Chapter will be host to the state organization at this meeting, and an interesting and instructive program, especially interesting to general practitioners, has been arranged. Details of the program will be announced in the coming issue of The Wisconsin Medical Journal.

The Wisconsin Chapter of the American Academy of General Practice now has approximately 500 members. The Madison Area Chapter, which was organized in June, has a membership of 29.

Incidence of Gastric and Duodenal Ulcers*

By WILLIAM L. WASKOW, M. D.
Madison

W. L. WASKOW

Roentgenologist at the Jackson Clinic in Madison, Doctor Waskow graduated from the University of Wisconsin Medical School in 1935. He was in residency at St. Luke's Hospital, Chicago, from 1936 to 1940, when he was certified as a diplomate of the American Board of Radiology. Following service in the United States Army Air Force, the doctor located in Madison in 1946.

DURING the year of 1947 the frequency of gastric ulcers seen by roentgen examination prompted a study of the incidence of gastric and duodenal ulcers. In that year a total of 148 ulcers were seen; of these, 37 were gastric and 111 were duodenal. This gave a ratio of one gastric ulcer to every three duodenal ulcers seen. Most of the published series on the incidence of peptic ulcer are based on autopsy and clinical findings, while only a few are based on roentgen findings.

The following study was made from the records of the x-ray department of the Jackson Clinic from 1942 to 1948 inclusive. The diagnoses were based on x-ray findings. All gastric ulcers included in the series were re-examined at regular intervals until they were healed or were proved benign ulcers upon surgical exploration.

Incidence

During this seven year period 4,280 gastrointestinal examinations were made. Of this number, 770 resulted in a diagnosis of peptic ulcer, or an incidence of 18 per cent. Table 1 gives the comparative incidence in other series also based on roentgen findings.

TABLE 1.—*Incidence of Peptic Ulcer*

Author	Cases	Incidence, %
Gorman	534	10
Eusterman and Balfour	15, 905	12.2
McMullen	4, 400	20
Percy and Beilin	1, 000	19.2
Waskow	4, 280	18

The seasonal recurrence of peptic ulcer in spring and fall was noted in the duodenal series. Gastric ulcers were found with equal frequency throughout the year.

Sex.—All published findings on peptic ulcer are in agreement that this disease predominates in the male. In this series 75 per cent occurred in males and 25 per cent in females. Table 2 gives the findings of many series.

TABLE 2.—*Occurrence of Peptic Ulcer in Male and Female*

Author	Male:Female
Lynch	2.7:1
Sturtevant and Shapiro	3:1
Sander	2.1:1
Eusterman and Balfour	4:1
McMullen	2.1:1
Portis and Jaffé	1.2:1
Gordon and Manning	2:1
Waskow	3:1

In both sexes the duodenal ulcer was more common than the gastric by a ratio of 4 to 1. Table 3 gives the percentages.

TABLE 3.—*Comparison of Duodenal and Gastric Ulcer in Male and Female*

	Duodenal		Gastric	
	No.	%	No.	%
Males	457	78	126	22
Females	153	81	34	19
Total	610	79	160	21

These findings are quite similar to those found by McMullen in his series based on roentgen findings. This series shows a slightly higher relative incidence of gastric ulcer in men than in women. McMullen, Tidy, and others reported a higher relative incidence of gastric ulcer in women than in men.

Anatomic Incidence.—Reference to the literature on the ratio of gastric to duodenal ulcer presented a confusing picture. The ratio varies from 2:1 to 1:28 for gastric to duodenal ulcer. This discrepancy can partly be explained by the fact that the high ratio of 2:1 reported by Osler in 1915 preceded the extensive use of the x-ray. At the other end of the register, the ratio of 1:28, obtained from an Army series by Chamberlin, can be explained by the young age of this group. Patterson's careful and complete study shows that the duodenal ulcer is by far the most prevalent in this country and Canada. The ratio of 1 to 3.8 of gastric to duodenal ulcer in this series compares well with the x-ray series by McMullen. However, in table 4 we see that most of the other authors give a higher incidence of duodenal ulcer.

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

TABLE 4.—*Ratio of Gastric to Duodenal Ulcer*

Author	Gastric:Duodena
Eusterman and Balfour	1:12.2
Dwyer and Blackford	1:9
Loder and Kornblum	no gastric ulcers
Chamberlin	1:28
Gorman	1:9
Percy and Beilin	1:8
McMullen	1:3.5
Waskow	1:3.8

Age

In this series the youngest patient was 19 years old, and the oldest, 81. The findings are summarized in Table 5.

TABLE 5.—*Age Incidence of Duodenal and Gastric Ulcer in Male and Female*

Age, Yr.	Males,		Females,	
	Duodenal, %	Gastric, %	Duodenal, %	Gastric, %
20–29	10	4	10	
30–39	22	4	10	15
40–49	34	25	36	25
50–59	19	34	31	60
60–69	11	33	10	
70	4		3	

Summary

1. In a total of 4,280 patients, 18 per cent were found to have peptic ulcer.

2. Twenty-one percent of the ulcerations were gastric, and 79 per cent were duodenal.

3. Twenty-five per cent of the ulcers occurred in females and 75 per cent in males.

4. In both sexes the greatest incidence of duodenal ulcer was found in those under the age of 50, while the incidence of gastric ulcer was greatest over 50.

The sites of the duodenal ulceration are not tabulated. Figure 1 shows the site of the gastric ulceration.

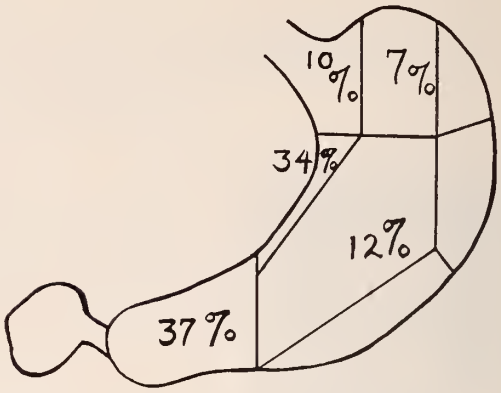

Fig. 1. Anatomic sites of gastric ulcers.

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AMERICAN BOARD OF INTERNAL MEDICINE ANNOUNCES EXAMINATION DATES

The American Board of Internal Medicine will hold a special oral examination, including the subspecialties, in Washington, D. C., October 26–28, and in New York December 7–9. The closing date for acceptance of applications is August 19. Candidates eligible this year cannot be admitted to oral examinations in 1951 unless illness interferes.

Complete SCIENTIFIC PROGRAM

★

1950 ANNUAL MEETING

STATE MEDICAL SOCIETY OF WISCONSIN

Milwaukee Auditorium ★ *Hotel Schroeder*

OCTOBER 2–3–4

Official Annual Meeting Notices

■ ADMITTANCE BY BADGE ONLY: Participation in the Annual Meeting is limited to paid members of the State Medical Society of Wisconsin and certified guests. Secure your badge and program at the registration desk in the Milwaukee Auditorium before the scientific sessions begin. If you lose your badge another may be secured.

■ CERTIFIED GUESTS: Arrangements have been made with the hospitals to admit interns and key hospital personnel as guests *if previously certified.* Residents will be admitted upon certification of the hospital. Out-of-state physicians who are full dues-paying members of their county and state medical societies can secure guest badges by presenting their membership cards.

■ REGISTRATION: Secure your badge at the registration desk, at the entrance of Bruce Hall, Milwaukee Auditorium, Kilbourn Street entrance. Registration hours: Monday and Tuesday: 7:30 a.m. to 5:00 p.m.; Wednesday: 8:00 a.m. to 3:00 p.m.

■ TELEPHONE SERVICE: *At Milwaukee Auditorium:* During scientific sessions, calls directed to physicians other than Milwaukee doctors should be directed to special phones installed. The numbers are Broadway 2–2523 and 2–2524. Calls for Milwaukee physicians should be directed to the Physicians Service Bureau (Marquette 8–4131), and they will be directed to a special phone in the Auditorium located near the main meeting hall. *At the Hotel Schroeder:* Delegates can be reached during sessions of the House (Sunday: 2:00–5:30 p.m.; Monday: 6:30–8:45; Tuesday: 9:00–10:00 a.m.) by having calls directed to the phone on the fifth floor foyer of the Hotel Schroeder (Marquette 8–7250). Those attending luncheons can be reached in the same manner between 12:15–2:15 p.m. each of the three days of the meeting.

■ SPECIAL CONCURRENT EVENTS: *Sunday:* Meetings of the Wisconsin Chapter of the American College of Chest Physicians (Crystal Ballroom, Hotel Schroeder) and the Wisconsin Society of Anesthesiologists (Parlor A, Hotel Schroeder). Golf Tournament at North Hills Country Club, 12:00 noon, *Wednesday,* October 4. Reservations at Registration Desk, Milwaukee Auditorium. Dinner and awards at 7:30 p.m. Marquette University Medical Alumni Association: luncheon at Blatz Auditorium, *Tuesday* noon, Oct. 3. Reservations made through the Marquette University Medical Alumni Assn. office, L533 W. Wisconsin Ave., Milwaukee. Max J. Fox, M.D., president, will be in charge of arrangements.

■ RESERVATIONS FOR ROUND-TABLE LUNCHEONS: Attendance limited as noted in program. Tickets can be secured at the Registration Desk in the Milwaukee Auditorium until 11:00 a.m. each day. If any tickets remain unsold they can be purchased at a special reservation table set up in the fifth floor foyer of the Hotel Schroeder at 11:30 a.m. each day.

■ DUPLICATE LUNCHEON TICKETS: If you have left your luncheon tickets at home please secure duplicates at the Registration Desk, as no one can be admitted to a luncheon without a ticket.

■ SPECIAL LUNCHEONS:

Monday: Past President's luncheon: Parlor G. By invitation only.
County Secretaries: East Room, fifth floor.

Tuesday: Special luncheon on personal tax problems: Crystal Ballroom.

Wednesday: Pathologists: Pere Marquette Room, fifth floor.
EENT: East Room, fifth floor.

■ MEDICAL MOTION PICTURES: Monday afternoon, all day Tuesday, and Wednesday morning a variety of medical motion pictures will be shown in Committee Room "D", on the second floor of the Milwaukee Auditorium, directly across from Plankinton Hall. See the program in September *Journal* for the schedule of showings and the details of the film content.

■ SESSIONS OF THE HOUSE: Opening session Sunday, October 1 at 2:00 p.m., buffet supper for all delegates, councilors, and officers at 5:30 p.m. Second session preceded by buffet supper in East Room, fifth floor, 5:30 p.m., Monday. Session from 6:30–8:45 p.m. Third session begins at 9:00 a.m., Tuesday, and will conclude around 10:00 a.m.

■ CLINICAL CONFERENCES: Three hospital staff conferences are to be held simultaneously at the Milwaukee Auditorium Monday morning. See program for details.

■ WISCONSIN WOMEN'S M.D. DINNER: The Wisconsin Women's Medical Society will hold a dinner meeting at 6:30 on Monday, October 2, in Parlor A, Hotel Schroeder. Amee Zillmer, of Madison, will speak on "New Trends in Social Hygiene," and her talk will be followed by a question and answer period. Reservations for the dinner should be sent to Dr. Alice Watts, 324 East Wisconsin Avenue, Milwaukee 2.

A New Annual Meeting Feature . . .

DAILY TEACHING DEMONSTRATIONS

Each day of the 1950 Annual Meeting a complete series of special teaching exhibits and demonstrations will be held in and around the exhibit hall as a means of providing more direct teaching and fewer didactic lectures. The following teaching exhibits or clinics will be held between 9:00 and 10:15 a. m. each day:

1. **OB MANIKIN DEMONSTRATIONS**—SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

   Special problems of delivery will be presented by a recognized teacher in the fields of obstetrics and gynecology. By use of a manikin the demonstrator will cover the use of forceps, breech presentation, and various methods of delivery as well as version and extraction. Opportunities will be offered for questions and discussion by those in attendance. Program arranged by Wisconsin Society of Obstetrics and Gynecology.

2. **FRACTURE DEMONSTRATIONS**—EXHIBIT HALL, MILWAUKEE AUDITORIUM

   This demonstration will be conducted by prominent Wisconsin orthopods, and will cover various topics related to the application of casts commonly applied. Details of the demonstrations are now being worked out and will be announced at a later date.

3. **BLOOD TRANSFUSIONS**—EXHIBIT HALL, MILWAUKEE AUDITORIUM

   The staff of Children's Hospital, Milwaukee, is presenting a special exhibit and demonstration on blood transfusions, with special reference to blood replacement in erythroblastosis. Various phases, such as blood matching and technics particularly related to pediatric practice will be featured in this daily demonstration.

4. **PATHOLOGIC CLINIC**—NORTH JUNEAU HALL, MILWAUKEE AUDITORIUM

   Each morning of the 1950 Annual Meeting the Wisconsin Society of Pathologists will conduct a pathologic clinic on a variety of subjects. This special teaching feature of the program will be supplemented by a gross tissue display and demonstration which will be held simultaneously in the exhibit hall. The following physicians will be in charge of the pathologic clinics: Monday, October 2, J. F. Kuzma, Milwaukee; Tuesday, October 3, D. M. Angevine, Madison; Wednesday, October 4, John B. Miale, Marshfield.

5. **ANATOMY DISSECTIONS**—EXHIBIT HALL, MILWAUKEE AUDITORIUM

   The Anatomy Department of the University of Wisconsin will conduct a demonstration of the nerves of the viscera and the surgical approaches to parts of the autonomic nervous system. This will consist of a dissection of the nerves in the neck, thorax, abdomen, and pelvis in one specimen. In another subject the demonstration will show the surgical approaches to, and exposure of, certain of the nerves.

6. **X-RAY INTERPRETATIONS**—WALKER HALL, MILWAUKEE AUDITORIUM

   The Wisconsin Radiologic Society will present a daily demonstration to provide those in attendance with a more complete interpretation of x-rays most closely related to general practice. These x-ray clinical conferences will be under the direction of S. A. Morton, M. D., Milwaukee, and L. W. Paul, M. D., Madison. This feature of the program is especially planned for physicians other than those in the specialty of radiology.

7. **ANESTHESIA DEMONSTRATIONS**—EXHIBIT HALL, MILWAUKEE AUDITORIUM

   The scientific exhibit prepared by the Wisconsin Society of Anesthesiologists will feature demonstrations on mechanical factors in control of spinal anesthesia and the physical factors involved in respiratory activity.

8. **THE ARTIFICIAL KIDNEY**—NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

   Arrangements have been made with the staff of Columbia Hospital, Milwaukee, to demonstrate the artificial kidney and explain its function in therapy.

Monday, Oct. 2 Highlights . . .

MONDAY, OCTOBER 2

To supplement the teaching demonstrations and exhibits described on page 687, the Council on Scientific Work has arranged to have the staffs of Children's Hospital, Milwaukee County Hospital, and Veterans Hospital, Wood, present the following staff conferences simultaneously on MONDAY, OCTOBER 2.

SURGICAL–MEDICAL STAFF CONFERENCE

Staff of Milwaukee County Hospital — Plankinton Hall, Milwaukee Auditorium

Joseph M. King, M. D., Chairman, Surgical Section
Francis Murphy, M. D., Chairman, Medical Section

10:30 a. m.: DIAGNOSIS AND TREATMENT — TUMOR OF URINARY BLADDER: Robert S. Irwin, M. D.

10:42 a. m.: MEDICAL DIAGNOSTIC PROBLEM: Joseph A. Bartos, M. D.

10:54 a. m.: PLANTAR ULCER IN A DIABETIC TREATED BY PLASTIC SURGERY: Volney B. Hyslop, M. D.

11:06 a. m.: FEVER CONVULSION: M. G. Peterman, M. D.

11:18 a. m.: SPONTANEOUS RUPTURE OF THE SPLEEN: E. A. Bachhuber, M. D.

11:26 a. m.: SALT DEPLETION AS A COMPLICATION IN THE TREATMENT OF HEART FAILURE: P. G. La Bissioniere, M. D.

PEDIATRIC STAFF CONFERENCE

Staff of Children's Hospital, Milwaukee — Walker Hall, Milwaukee Auditorium

Frank J. Mellencamp, M. D., Chairman

10:30 a. m.: NEPHRITIS: Ted Buszkiewicz, M. D.

10:45 a. m.: DIABETES: Karl Beck, M. D.

11:00 a. m.: CONVULSIVE DISORDERS: Niels Low, M. D.

11:15 a. m.: COMMON SKIN LESIONS IN CHILDHOOD: Donald M. Ruch, M. D.

11:30 a. m.: HEMATOLOGIC CASES: Dann B. Claudon, M. D.

SUPPURATIVE PULMONARY DISEASES

Staff of Veterans Hospital, Wood — Engelmann Hall, Milwaukee Auditorium

Maurice Hardgrove, M. D., Chairman

10:30–11:00 a. m.: MEDICAL ASPECTS OF SUPPURATIVE PULMONARY DISEASES: George C. Owen, M. D., and Donald M. Willson, M. D.

11:00–11:30 a. m.: SURGICAL ASPECTS OF SUPPURATIVE PULMONARY DISEASES: Forrester Raine, M. D., and Wilson Weisel, M. D.

All presentations will feature use of patients.

General Program, Monday, Oct. 2

PLANKINTON HALL, MILWAUKEE AUDITORIUM

HUGH McCULLOCH, M. D.
Chicago

F. W. MADISON, M. D.
Chairman

FRANCIS D. MURPHY, M. D.
Milwaukee

2:25 p. m.: OPENING OF SCIENTIFIC PROGRAM
J. Wm. Truitt, M. D., President

2:30 p. m.: RECENT ADVANCES IN RHEUMATIC FEVER: Hugh McCulloch, M. D., La Rabida Jackson Park Sanitarium, Chicago
(Lecture sponsored by Wisconsin Heart Association)

3:00 p. m.: ACUTE NEPHRITIS AND LOWER NEPHRON NEPHROSIS: Francis D. Murphy, M. D., clinical professor and director of the department of medicine, Marquette University School of Medicine

3:30 p. m.: RECESS TO VIEW EXHIBITS

4:15 p. m.: MULTIPLE SCLEROSIS: A. B. Baker, M. D., professor and director of the division of neurology, University of Minnesota Medical School, Minneapolis
(Theresa Rogers Memorial Lecture)

4:45 p. m.: RECENT ADVANCES IN THE FIELD OF ANESTHESIOLOGY: Stuart C. Cullen, M. D., professor of surgery, chairman of the division of anesthesiology, University of Iowa College of Medicine, Iowa City

A. B. BAKER, M. D.
Minneapolis

STUART C. CULLEN, M. D.
Iowa City

GUEST SPEAKERS ON SECTION PROGRAMS

J. W. CONN, M. D.
Internal Medicine

WM. F. HUGHES, M. D.
Ophthalmology

H. DABNEY KERR, M. D.
Radiology

CHAS. W. MUELLER, M. D.
Obstetrics and Gynecology

SCIENTIFIC

ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

MONDAY ★ HOTEL SCHROEDER ★ OCTOBER 2

FOURTH FLOOR MEETING ROOMS

*1. Parlor A: RHEUMATIC HEART DISEASE: Hugh McCulloch, M. D., LaRadida Jackson Park Sanitarium, Chicago

2. Parlor B: COMMON NEUROLOGIC PROBLEMS: A. B. Baker, M. D., professor of neurology, and head of division of neurology, University of Minnesota Medical School

*3. Parlor C: NEWER DRUGS AND THEIR USES: W. S. Middleton, M. D., professor of medicine and dean, University of Wisconsin Medical School

4. Parlor D: ACUTE NEPHRITIS: F. D. Murphy, M. D., clinical professor and director of division of radiology, Marquette University School of Medicine

5. Parlor E: INFERTILITY: Roland Cron, M. D., professor and head of the department of obstetrics and gynecology, Marquette University School of Medicine

*6. Parlor F: ACTH AND CORTISONE: E. S. Gordon, M. D., associate professor of medicine, University of Wisconsin Medical School

7. Parlor H: VIRUS DISEASE PREVENTION: A. R. Zintek, M. D., director of preventable diseases, Wisconsin State Board of Health

8. Parlor I: PROBLEMS IN ANESTHESIA: Stuart C. Cullen, M. D., professor of surgery, chairman, division of anesthesiology, University of Iowa College of Medicine

SPECIAL LUNCHEON—FOURTH FLOOR

9. Parlor G: Past President's Luncheon: Guest luncheon for all past presidents of the SMS and President-Elect. By invitation only. No charge for luncheon.

FIFTH FLOOR MEETING ROOMS

10. Private Dining Room 507: PRESENT STATUS OF SURGICAL TREATMENT OF THYROID DISEASE: Carl Eberbach, M. D., clinical professor and director of division of surgery, Marquette University School of Medicine

11. Private Dining Room 508: MANAGEMENT OF HAND INJURIES: William Frackelton, M. D., assistant clinical professor of surgery, Marquette University School of Medicine

12. Private Dining Room D: RH PROBLEMS: Tibor Greenwalt, M. D., clinical instructor in medicine, Marquette University School of Medicine

*13. Committee Room: ERUPTIONS OF THE HANDS AND FEET: S. A. M. Johnson, M. D., professor of dermatology and syphilology, University of Wisconsin Medical School

14. Pine Room: RECENT ADVANCES IN HEMATOLOGY: John Hirschboeck, M. D., professor of medicine and dean of Marquette University School of Medicine

15. Pere Marquette Room: DISCUSSION OF SOME PROBLEMS OF GYNECOLOGIC PLASTIC SURGERY: Ralph Campbell, M. D., professor of obstetrics and gynecology, University of Wisconsin Medical School

SPECIAL LUNCHEON—FIFTH FLOOR

16. East Room: County Secretaries: Special luncheon for county secretaries, furnished by SMS, at which county officers will meet with SMS and AMA officials.

Note: No charge for this luncheon, so do not include payment in your reservation.

* Luncheon filled—no more reservations available!

[USE RESERVATION BLANK, PAGE 703]

General Program, Tuesday, Oct. 3

Morning Session:

9:00–10:15 a. m.: SPECIAL TEACHING DEMONSTRATIONS
See page 687 for a description of these important teaching programs. All will be held simultaneously in the areas indicated.

10:20–11:50 a. m.: GENERAL ASSEMBLY—PLANKINTON HALL, MILWAUKEE AUDITORIUM

FRANCIS LEDERER, M. D.
Chicago

W. S. BUMP, M. D.
Chairman

10:20 a. m.: A TWENTY YEAR ANALYSIS OF HYSTERECTOMIES PERFORMED IN ROCK COUNTY: E. W. Reinardy, M. D., Janesville

10:50 a. m.: THE USE OF ANTIBIOTICS IN OTOLARYNGOLOGY: Francis L. Lederer, M. D., professor and head of the department of otolaryngology, University of Illinois College of Medicine

11:20 a. m.: ACUTE ASEPTIC MENINGITIS: W. D. Sutliff, M. D., Chief, Infectious Disease Section, V. A. Hospital, Memphis, Tenn.

W. D. SUTLIFF, M. D.
Memphis, Tenn.

SEE NEXT PAGE FOR TUESDAY NOON ROUND-TABLE LUNCHEONS

Afternoon Session:

DANIEL C. DARROW, M. D.
New Haven, Conn.

MICHAEL JORDAN, M. D.
New York City

T. O. NUZUM, M. D.
Chairman

2:30 p. m.: FLUID THERAPY WITH SPECIAL REFERENCE TO THE ROLE OF POTASSIUM: Daniel C. Darrow, M. D., professor of pediatrics, Yale University School of Medicine, New Haven, Conn.

3:00 p. m.: EARLY DIAGNOSIS OF UTERINE CANCER AND ITS MANAGEMENT: Michael J. Jordan, M. D., associate professor of clinical obstetrics and gynecology, New York University College of Medicine, New York City

3:30 p. m.: RECESS TO VIEW EXHIBITS

4:15 p. m.: THE SURGICAL MANAGEMENT OF THYROID DISEASES: Richard Cattell, M. D., Lahey Clinic, Boston

4:45 p. m.: RECENT ADVANCES IN THE TREATMENT OF RESPIRATORY DISEASES: Yale Kneeland, Jr., M. D., associate professor of medicine, Columbia University, New York City

RICHARD CATTELL, M. D.
Boston

YALE KNEELAND, JR., M. D.
New York City

SCIENTIFIC

ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

TUESDAY ★ HOTEL SCHROEDER ★ OCTOBER 3

FOURTH FLOOR MEETING ROOMS

★1. Parlor A: PSYCHOTHERAPY IN GENERAL PRACTICE: John Schindler, M. D., Monroe

2. Parlor B: DRUGS IN THE CONTROL OF PAIN: Harry Beckman, M. D., professor and director, department of pharmacology, Marquette University School of Medicine

3. Parlor C: ANTIBIOTICS IN OTOLARYNGOLOGY: Francis Lederer, M. D., professor of otolaryngology and head of department of otolaryngology and rhinology, University of Illinois College of Medicine, Chicago

4. Parlor D: VIRUS INFECTIONS OF THE NERVOUS SYSTEM: W. D. Sutliff, M. D., V. A. Hospital, Memphis, Tennessee

5. Parlor E: SURGICAL TREATMENT OF ADVANCED CARCINOMA OF THE PELVIS: Michael J. Jordan, M. D., associate professor of clinical obstetrics and gynecology, New York University–Bellevue Medical Center, New York City

★6. Parlor F: THE MANAGEMENT OF HYPERTENSION: Chester M. Kurtz, M. D., associate professor of medicine, University of Wisconsin Medical School

7. Parlor G: CANCER OF THE PROSTATE: John B. Wear, M. D., associate professor of urology, University of Wisconsin Medical School

8. Parlor H: PULMONARY TUBERCULOSIS: A. V. Cadden, M. D., associate clinical professor of medicine, Marquette University School of Medicine

★ Luncheon filled—no more reservations available!

FIFTH FLOOR MEETING ROOMS

9. Parlor I: NON-GLOMERULONEPHRITIC RENAL DISEASE: W. A. D. Anderson, M. D., professor of pathology, Marquette University School of Medicine

★10. Private Dining Room 507: NEWER DRUGS AND THEIR USES: Ovid Meyer, M. D., professor of medicine, University of Wisconsin Medical School

11. Private Dining Room 508: CARDIAC ARRHYTHMIAS: Francis F. Rosenbaum, M. D., assistant clinical professor of medicine, Marquette University School of Medicine

12. Private Dining Room 509: DIABETES MELLITUS: Bruno J. Peters, M. D., clinical instructor in medicine, Marquette University School of Medicine

13. Committee Room: UTERINE SURGERY: Paul Doege, M. D., Marshfield

14. Pine Room: THE MANAGEMENT OF ALCOHOLISM: Fritz Kant, M. D., professor of neurology and psychiatry, University of Wisconsin Medical School

15. Pere Marquette Room: BACK ACHE: Robert E. Burns, M. D., professor of orthopedic surgery, University of Wisconsin Medical School

SPECIAL LUNCHEON—FIFTH FLOOR

16. Ballroom: COMMON ADMINISTRATIVE AND PERSONAL TAX PROBLEMS CONFRONTING PHYSICIANS: Mr. Robert Murphy, Madison, legal counsel of the SMS and Mr. Alfred Granum, Amery, insurance specialist.

[USE RESERVATION BLANK, PAGE 703]

General Program, Wednesday, Oct. 4

9:00–10:15 a. m.: SPECIAL TEACHING DEMONSTRATIONS (See page 687 for details)

OB Manikin Demonstration:
Fractures and Application of Casts
Blood Transfusions of Children
Pathologic Clinic

Anatomy Dissections
X-Ray Interpretations
Anesthesia Demonstrations
The Artificial Kidney

10:20–11:50 a. m.: GENERAL ASSEMBLY—PLANKINTON HALL, MILWAUKEE AUDITORIUM

LEO RIGLER, M. D.
Minneapolis

J. BARRETT BROWN, M. D.
St. Louis

JOSEPH JOHNSTON, M. D.
Detroit

10:20 a. m.: THE SPECIAL PROBLEMS OF THE ADOLESCENT CHILD: Joseph A. Johnston, M. D., pediatrician-in-chief, Henry Ford Hospital, Detroit

10:50 a. m.: THE LIMITATIONS AND POSSIBILITIES OF ROENTGEN DIAGNOSIS: Leo Rigler, M. D., professor of radiology and chief of the department of radiology, University of Minnesota Medical School, Minneapolis

11:20 a. m.: MANAGEMENT OF TUMORS OF THE FACE, MOUTH AND JAWS: J. Barrett Brown, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis

SEE NEXT PAGE FOR WEDNESDAY NOON ROUND-TABLE LUNCHEONS

MR. CECIL PALMER

How Close Are We to Socialism?

Is the British Welfare State Working?

Hear:

"STATE MEDICINE—PROMISE and FULFILLMENT"

CECIL PALMER

Eminent British Publisher and Lecturer

Annual Dinner, Tuesday, Oct. 3

ONLY 450 TICKETS! ORDER ON BLANK, PAGE 703

SCIENTIFIC

ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

WEDNESDAY ★ HOTEL SCHROEDER ★ OCTOBER 4

FOURTH FLOOR MEETING ROOMS

1. Parlor A: MANAGEMENT OF COMPOUND INJURIES OF THE FACE AND JAWS: J. Barrett Brown, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis

2. Parlor B: MENINGITIS: Yale Kneeland, M. D., associate professor of medicine, Columbia University, New York City

*3. Parlor C: THE SELYE ALARM REACTION IN CLINICAL MEDICINE: Jerome W. Conn, M. D., associate professor of internal medicine, University of Michigan Medical School, Ann Arbor

*4. Parlor D: WATER AND ELECTROLYTE BALANCE: Daniel C. Darrow, M. D., professor of pediatrics, Yale University School of Medicine, New Haven, Conn.

5. Parlor E: CHRONIC INTESTINAL INDIGESTION: Joseph A. Johnston, M. D., pediatrician-in-chief, Henry Ford Hospital, Detroit

6. Parlor F: IRRADIATION THERAPY OF PELVIC NEOPLASMS: H. Dabney Kerr, M. D., professor of radiology, University of Iowa College of Medicine, Iowa City

7. Parlor G: PROBLEMS IN PEDIATRIC SURGERY: P. F. Hausmann, M. D., clinical instructor in surgery, Marquette University School of Medicine

8. Parlor H: WHAT'S NEW IN POISONS?: Elston L. Belknap, M. D., associate clinical professor of medicine, Marquette University School of Medicine

9. Parlor I: EMOTIONAL DEVELOPMENT IN CHILDREN: H. Kent Tenney, Jr., M. D., associate professor of pediatrics, University of Wisconsin Medical School

* Luncheon filled—no more reservations available!

FIFTH FLOOR MEETING ROOMS

10. Private Dining Room 507: MASS SURVEY ROENTGEN EXAMINATIONS: Leo Rigler, M. D., professor of radiology, University of Minnesota Medical School

*11. Private Dining Room 508: ULCERATIVE COLITIS: Richard Cattell, M.D., Lahey Clinic, Boston

12. Private Dining Room 509: AIDS TO RURAL PRACTITIONERS IN THE RECOGNITION OF EARLY CANCER (Including Biopsy and Other Techniques): W. D. Stovall, M. D., professor of hygiene, University of Wisconsin Medical School and director of State Laboratory of Hygiene; and A. R. Curreri, M. D., associate professor of surgery, University of Wisconsin Medical School

13. Committee Room: THE MATERNAL MORTALITY COMMITTEE—ITS APPLICATION BY LOCAL AND STATE SOCIETIES: Charles W. Mueller, M. D., Kings County Hospital, Brooklyn, N. Y.

*14. Pine Room: PAINFUL SHOULDERS: Herman Schumm, M. D., associate clinical professor of orthopedic surgery and director of department of orthopedic surgery, Marquette University School of Medicine

15. Pere Marquette Room: OBSERVATIONS ON THE PATHOLOGY OF FIBROCYSTIC LESIONS OF BONE: G. A. Bennett, M. D., professor of pathology, University of Illinois College of Medicine, Chicago

Note: After luncheon the Wisconsin Society of Pathologists will meet, but luncheon for general practitioners as well as pathologists.

SPECIAL LUNCHEON—FIFTH FLOOR

16. East Room: EENT Luncheon. Special luncheon for all those attending Section meeting. Informal discussion of EENT problems following luncheon and preceding afternoon scientific program. *All EENT members please register for this luncheon.*

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SECTION MEETINGS—WEDNESDAY, OCT. 4

INTERNAL MEDICINE—PLANKINTON HALL, AUDITORIUM

V. F. LANG, M. D., Milwaukee, Chairman

2:30 p. m.: RECENT ADVANCES IN THE USE OF BAL: Elston L. Belknap, M. D., associate clinical professor of medicine, Marquette University School of Medicine

2:50 p. m.: BACTERIAL AND NON-BACTERIAL INFECTIONS OF THE RESPIRATORY TRACT: Yale Kneeland, Jr., M. D., associate professor of medicine, Columbia University, New York City

3:20 p. m.: RECESS (10 minutes)

3:30 p. m.: RECENT ADVANCES IN VIRUS AND RICKETTSIAL DISEASES: W. D. Sutliff, M. D., Chief, Infectious Disease Section, Veterans Hospital, Memphis, Tenn.

4:00 p. m.: CLINICAL IMPLICATIONS OF ACTH AND CORTISONE: Jerome W. Conn, professor of internal medicine, University of Michigan Medical School, Ann Arbor

OBSTETRICS & GYNECOLOGY—JUNEAU HALL, AUDITORIUM

J. F. EGAN, M. D., La Crosse, Chairman

2:30 p. m.: THE SURGICAL MANAGEMENT OF UTERINE PROLAPSE: B. E. Urdan, M. D., associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine

2:50 p. m.: ADVANCES IN THE TREATMENT OF CARCINOMA OF THE CERVIX, AND EVALUATION OF THE SURGICAL MANAGEMENT: Michael J. Jordan, M. D., associate professor of clinical obstetrics and gynecology, New York University College of Medicine

3:20 p. m.: RECESS (10 minutes)

3:30 p. m.: THE OBSTETRICIAN'S RESPONSIBILITY IN THE PROBLEM OF PREMATURITY: John W. Harris, M. D., professor of obstetrics and gynecology, University of Wisconsin Medical School

3:50 p. m.: CHORIONEPITHELIOMA OF THE UTERUS: Charles W. Mueller, M. D., Kings County Hospital, Brooklyn

OPHTHALMOLOGY & OTOLARYNGOLOGY—

LUNCHEON AND MEETING IN EAST ROOM, HOTEL SCHROEDER

EDWARD J. ZEISS, M. D., Appleton, Chairman

2:00 p. m.: RETINAL DETACHMENT: William F. Hughes, M. D., professor and head of the department of ophthalmology, University of Illinois College of Medicine, Chicago

2:30 p. m.: ACOUSTIC TRAUMA: Meyer S. Fox, M. D., Milwaukee

2:50 p. m.: OCULAR SARCOIDOSIS: Austin G. Dunn, M. D., Stevens Point

3:10 p. m.: PRACTICAL APPROACHES TO OTOLARYNGOLOGY: Francis L. Lederer, M. D., professor and head of the department of otolaryngology, University of Illinois College of Medicine, Chicago

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SECTION PROGRAMS—WEDNESDAY AFTERNOON (Continued)

PEDIATRICS—KILBOURN HALL, AUDITORIUM

K. B. McDONOUGH, M. D., Madison, Chairman

2:30 p. m.: DIAGNOSIS AND TREATMENT OF FIBROCYSTIC DISEASES OF THE PANCREAS: John E. Gonce, Jr., M. D., professor of pediatrics, University of Wisconsin Medical School

2:50 p. m.: THE TREATMENT OF DISTURBANCES IN WATER AND ELECTOLYTES IN INFANTILE DIARRHEA: Daniel C. Darrow, M. D., professor of pediatrics, Yale University School of Medicine, New Haven, Conn.

3:20 p. m.: RECESS (10 minutes)

3:30 p. m.: PROBLEMS IN PEDIATRIC SURGERY: Arthur A. Schaefer, M. D., associate clinical professor of surgery, Marquette University School of Medicine

3:50 p. m.: THE FACTORS WHICH AFFECT GROWTH AS MEASURED BY NITROGEN AND CALCIUM STUDIES: Joseph A. Johnston, M. D., pediatrician-in-chief, Henry Ford Hospital, Detroit

RADIOLOGY—WALKER HALL, AUDITORIUM

H. H. WRIGHT, M. D., Milwaukee, Chairman

2:30 p. m.: THE PHYSIOLOGIC AND ANATOMIC BASIS FOR ROENTGEN DIAGNOSIS OF PULMONARY DISEASE: Leo Rigler, M. D., professor of radiology and chief of the department of radiology, University of Minnesota Medical School, Minneapolis

3:00 p. m.: RADIATION THERAPY OF INTRACRANIAL NEOPLASMS: H. Dabney Kerr, M. D., professor of radiology, University of Iowa College of Medicine, Iowa City

3:30–4:15 p. m.: Case Studies of Special Radiologic Interest

3:30 p. m.: SOME EXPERIENCES WITH NEO-IOPAX IN EXCRETORY UROGRAPHY: H. W. Hefke, M. D., associate clinical professor of radiology, Marquette University School of Medicine, and J. L. Armbruster, M. D., assistant clinical professor of radiology, Marquette University School of Medicine

3:45 p. m.: A CASE OF LYMPHOBLASTOMA WITH UNUSUAL SKIN TUMEFACTIONS: E. A. Pohle, M. D., professor of radiology, University of Wisconsin Medical School

4:00 p. m.: A NEW CLINICO-ROENTGENOLOGIC CLASSIFICATION OF CONGENITAL HEART DISEASE: J. L. Marks, M. D., clinical instructor of radiology, Marquette University School of Medicine

4:15 p. m.: Business meeting and election of officers

SURGERY—ENGELMANN HALL, AUDITORIUM

FORRESTER RAINE, M. D., Milwaukee, Chairman

2:30 p. m.: THE SURGICAL MANAGEMENT OF CARCINOMA OF THE COLON: Frank D. Weeks, M. D., Ashland

2:50 p. m.: SURGICAL REPAIR OF RADIATION LESIONS, INCLUDING THOSE OF ATOMIC ORIGIN: J. Barrett Brown, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis, Mo.

3:20 p. m.: SUBTOTAL GASTERECTOMY IN THE TREATMENT OF PEPTIC ULCERS: W. B. Gnagi, Jr., M. D., Monroe

3:50 p. m.: PRESENT STATUS OF SURGERY OF THE PANCREAS: Richard B. Cattell, M. D., Lahey Clinic, Boston

4:20 p. m.: Discussion of the papers presented

T. O. NUZUM

Scientific Exhibits

PREPARED BY T. O. NUZUM, M.D., JANESVILLE, MEMBER, COUNCIL ON SCIENTIFIC WORK

The Scientific Exhibits for the 1950 Annual Meeting are located at the north end of the arena of the Milwaukee Auditorium. Time will be allowed in the program schedule each day to permit the viewing of scientific and technical exhibits.

S–7a USE OF RADIOACTIVE IODINE IN THYROID DISEASE

Department of medicine, University of Wisconsin Medical School

(E. S. Gordon, M.D. and Edwin Albright, M.D., in charge of the exhibit)

X-ray plates in cancer of the thyroid will show the condition before and after treatment with radioactive iodine. Histologic sections of the same lesions will be shown as well as histologic sections of the thyroid gland after treatment of thyrotoxicosis with radioactive iodine. Numerous charts will show the use of radioactive iodine in both diagnosis and therapy, and a Geiger counter with radioactive iodine will be attended by an assistant, so that visitors will be able to see the apparatus in use. By this means, it is hoped to give a complete picture of this new therapeutic tool in thyroid disease.

S–8 ELECTROENCEPHALOGRAPHY

Marquette University School of Medicine and Veterans Hospital, Wood

(Exhibit under direction of Francis J. Millen, M.D. and Edward D. Schwade, M.D.)

The exhibit will first feature a briefly worded description of the pertinent facts concerning the field of electroencephalography by means of placards, to orient the general practitioner and other medical men in the specialties with this relatively new form of electrodiagnosis. Illustrations will include brief historical facts, technics, indications for the electroencephalogram, and a number of other pertinent data. Included also will be about 50 to 100 parts of actual electroencephalograms to demonstrate its many uses. There may also be available an electroencephalographic recording apparatus for demonstration purposes.

S–9 MILWAUKEE'S BLOOD SERVICE PROGRAM

Junior League Blood Center, Milwaukee

(Tibor Greenwalt, M.D., medical director, in charge of the exhibit)

The exhibit will be a statistical report of the activities of the blood center and will describe the replacement program, the donor club organization, the Maternity Care Insurance Policy, and the Rh diagnostic service. The various products supplied will be mentioned. The newer and more reliable methods of cross-matching will be stressed.

S–10 S–11 HOW A LOCAL HEALTH DEPARTMENT CAN FACILITATE THE SCIENTIFIC PRACTICE OF MEDICINE

Wisconsin State Board of Health

The scientific practice of medicine is facilitated by the seven basic functions of the local health department. Animated charts, photo murals, and colored slides show the value derived by the practicing physician from the following services: *Vital Statistics* of local origin reveal present and pending local health problems; *Health Education* motivates regular visits to the physician; *Laboratory Facilities* close at hand furnish fast confirmation of diagnoses; *Environmental Sanitation* in local areas helps eliminate typhoid and gastroenteritis; *Maternal and Child Health* classes and visits encourage prenatal and postnatal care for each mother by her physician; *Communicable Disease Control* promotes immunization in the general practitioner's office; *Geriatric Service* urges regular medical examinations to detect early degenerative diseases past middle life.

S–12 RHEUMATIC DISEASES

Wisconsin Rheumatism Association

(Mark W. Garry, chief of medical service, Veterans Hospital, Wood, in charge of the exhibit)

I. Reflex Dystrophy of the Upper Extremity: Reflex dystrophy of the upper extremity repre-

sents an effect of, rather than a cause for, disease. A variety of etiologic factors may precipitate the syndrome. Charts, models, and clinical photographs will be presented to delineate a working hypothesis useful in explaining the mechanics of the disorder and to show the form of treatment employed in cervical intraforaminal disease, Sudeck's atrophy, postinfarctional and posthemiplegic syndromes, causalgia, etc.

II. Orthopedic Medical Management of Arthritis: The exhibit will demonstrate photographs of typical deformities, diagrams explaining development of deformities, and models showing treatment, changing treatment, and preventive measures used against usual anticipated complications.

S–13 SOME NUTRITIONAL STUDIES IN TUBERCULOSIS IN ADOLESCENT GIRLS

Joseph A. Johnston, M.D., pediatrician-in-chief, Henry Ford Hospital, Detroit

A series of nutritional studies on adolescent girls with tuberculosis, using the nitrogen and calcium balances, is presented. Separate studies on the factors affecting the balances are presented. Correlations are demonstrated between healing and positive storages, on the one hand, and spread and failure to store, on the other.

S–14 CARCINOMA OF THE CERVIX

Paul F. Doege, M.D., Marshfield

The exhibit will include a classification of the types of carcinoma of the cervix with special emphasis on the minimal histologic changes in the epithelium which cause one to suspect cancer and eventually prove its presence. The entire exhibit is delivered in the form of a short lecture which is projected in full color, the slides being synchronized with a recorded explanation of the material presented. The exhibit will be so arranged that a complete story will be retold every ten minutes throughout the day.

S–15 SIGNIFICANT RADIOLOGIC STUDIES

S–16 Wisconsin Radiologic Society

S–17

(Exhibit under the direction of R. W. Byrne, M.D.)

The exhibit will consist of individual visual discussions of the following topics: "Asymptomatic Pulmonary Lesion," by Dr. Lester Paul, Madison; "X-Ray Aspects of Gastrointestinal Tract Bleeding," by Drs. S. A. Morton and R. W. Byrne, Milwaukee; "Early Bronchogenic Carcinoma," by Dr. T. J. Pfeffer, Milwaukee; "Routine Roentgen Pelvimetry," by Drs. A. Melamed and A. Marck, Milwaukee; "A Method of Small Bowel Study: Segmental Examination with a Double Lumen Tube," by Dr. J. L. Marks, Milwaukee; "Congenital Dysplasia of the Acetabulum or Congenital Dislocation of the Hip," by Dr. E. Pitts, Racine; and a discussion by Dr. C. E. Schmidt, Milwaukee, whose subject has not yet been announced.

S–18 APPENDICITIS

S–19 Jackson Clinic, Madison

(Exhibit under the direction of George P. Schwei, M.D., Arnold S. Jackson, M.D., and John R. Steeper, M.D.)

This exhibit, consisting of moulages, kodachrome pictures, and charts, will demonstrate the end results of a study of over 4,000 cases of appendicitis observed at the Jackson Clinic during the years 1922 to 1950. Included in the exhibit are a tabulation of the important diagnostic signs and symptoms; moulages demonstrating the steps in the surgical technic; kodachromes of gross specimens with accompanying case histories and postoperative results. A special study of 25 cases of perforated appendices with peritonitis, treated by appendectomy without surgical drainage, chemotherapy, antibiotics, and early ambulation is presented. Charts showing the decrease in morbidity and mortality in the United States and Wisconsin are emphasized.

S–19A DISEASES OF THE VEINS

James M. Sullivan, M.D., Robert Frisch, M.D., and Ray Piaskoski, M.D., Milwaukee

The exhibit will be divided into two sections. One section will depict diagnostic measures used for varicose veins together with charts illustrating various tests. The treatment of varicose veins by stripping will be illustrated by photographs, presentation of instruments, etc. Comparison of the results from the stripping operation with previous methods of treatment will be given.

The second portion of the exhibit will concern itself with thrombophlebitis. Diagnosis will be illustrated by photographs of venograms and the illustration of other diagnostic procedures. The treatment of thrombophlebitis will be considered from both the surgical angle and the medical angle. Ligations and sympathectomy will be compared with anticoagulant therapy.

S–20 PROTRUDED INTERVERTEBRAL DISK

Henry M. Suckle, M.D., Madison, and Madison General Hospital

The signs, symptoms, diagnosis, and treatment of protruded intervertebral disks will be presented. The location and radiation of pain in the spine and in the extremities, concomitant scoliosis, weakness, atrophy, and reflex changes will be outlined. The location of the disk protrusions and their relative frequency in the cervical and lumbar regions will be noted. The physiologic basis of the signs and symptoms dependent on specific nerve root compression will be explained. The value of routine spine x-rays and myelography will be defined and representative roentgenograms will be exhibited. The basis for diagnosis dependent on the symptoms, signs, and roentgen examination will be presented. The conservative treatment and the surgical procedures for the removal of protruded intervertebral disks will be depicted with illustrations.

S–21 HEMANGIOMA

Wayne B. Slaughter, M.D., and Associates, University of Wisconsin Medical School

This exhibit will consist of 300 cases of mixed type hemangiomas treated by various methods. These include x-ray, carbon dioxide, cautery and sclerosing agents. The pathology present and the response are shown on photomicrographs. The conclusions are that sclerosing agents are superior because of little or no damage to overlying skin and no interference with growth centers.

S–22 THE DIAGNOSIS AND TREATMENT OF HERNIATED INTERVERTEBRAL DISKS IN THE CERVICAL, THORACIC, LUMBAR AND LUMBOSACRAL REGIONS

David Cleveland, M.D., and E. J. Kiefer, M.D., Milwaukee, in cooperation with Veterans Administration Hospital, Wood

The exhibit will be made up of x-rays showing the various lesions, as demonstrated by myelographic study, and also x-rays of the spine in the various regions, showing pathology occasionally seen with intervertebral disks. There will be photographs of patients preoperatively and postoperatively; photographs of the specimens removed at operation and charts illustrating methods of diagnosis, based on subjective and objective findings and pictures illustrating operative findings.

S–23 DISEASES OF THE THORAX

Departments of surgery, pathology, medicine, and radiology, University of Wisconsin Medical School

(Joseph W. Gale, M.D., professor of surgery, in charge of the exhibit)

This exhibit consists of a clinical and pathologic study of diseases of the thorax. Kodachrome photographs showing gross and microscopic specimens along with a clinical history of each case are shown. The exhibit includes new growths of the lung and mediastinum, inflammatory diseases of the lung. Other studies included in the exhibit are bronchial adenoma, carcinoma and mediastinal tumors. One especially interesting case of adenomatosis and two cases of coccidioidomycosis of the lung are included.

S–24 CANCER OF THE BREAST

S–25

(A. R. Curreri, M.D., associate professor of surgery, in charge of this portion of the exhibit)

CANCER OF THE RECTUM

(E. R. Schmidt, M.D., professor of surgery, in charge of this portion of the exhibit)

Department of surgery, University of Wisconsin Medical School

The part of the exhibit demonstrating cancer of the breast will emphasize the statistical, early diagnostic, and treatment phases. Methods of breast examination, findings in early cancer, indications for biopsy and surgical treatment, and end results from treatment will be illustrated.

The portion of the exhibit which concerns itself with carcinoma of the rectum will demonstrate briefly the present statistical survival rate as compared to possible optimum survival rates. Methods of diagnosis, including history, physical, rectal, and proctoscopic examinations, will be shown by color transparencies. Furthermore, the various types of lesions seen in the rectum and sigmoid will be presented.

S–26A *APPLICATION OF CASTS

S–33A

(Exhibit and demonstration presented by the Wisconsin Society of Orthopedic Surgery)

This exhibit and demonstration will be one of 8 featured teaching programs carried on each morning from 9:00–10:20 a.m., and also during the afternoon recess period. Various types of casts will be applied by Wisconsin orthopedists, serving as teachers and demonstrators.

S–26 *THE NERVES TO THE VISCERA AND THE

S–27 SURGICAL APPROACHES TO PARTS OF THE AUTONOMIC NERVOUS SYSTEM

Department of anatomy, University of Wisconsin Medical School

(Exhibit in charge of Frederick D. Geist, M.D. and Otto Mortensen, M.D.)

The exhibit and demonstration will present a dissection of the nerves in the neck, thorax, abdomen, and pelvis in one specimen. In another subject the demonstrators will show the surgical approaches to, and exposure of, certain of the nerves.

This scientific exhibit will be one of 8 demonstrations every morning from 9:00–10:20, at which time special lectures will be held.

S–28 *SPINAL ANESTHESIA

S–29 *THE FUNCTION OF RESPIRATION

Department of anesthesiology, University of Wisconsin Medical School

(The exhibit and demonstration will be under direction of Simpson S. Burke, M.D., assistant professor of anesthesia)

The exhibit will consist of two demonstrations, probably to be staged alternately. The first demonstration is the hydrodynamics of spinal anesthesia. A short, simple demonstration of some of the elementary factors affecting the administration of spinal anesthetics will be presented. The presentation will take 15–20 minutes. It is intended to show as simply as possible some of the effects of common procedures and ordinary errors of technic. The other demonstration will show with a plastic mechanical model various aspects of the function of respiration showing alterations in pressures and air exchange under conditions which ordinarily have adverse effects on the respiration of patients.

This scientific exhibit will be one of 8 demonstrations every morning from 9:00–10:20, as well as during the afternoon recess period.

S–30 DIABETES MELLITUS

S–31 Marquette University School of Medicine, United States Public Health Service, and Veterans Hospital, Wood

(Exhibit under the direction of Bruno J. Peters, M.D., J. M. Meyer, M.D. and Maurice Hardgrove, M.D.)

This exhibit is to be a statistical summary of the diabetic survey being conducted in Milwaukee. The survey at present is under the direction of the Medical Society of Milwaukee County, United States Public Health Service, and the Milwaukee Health Department. The procedures being used in conducting this survey will be displayed; the number of patients tested to date together with the number of proved cases will be summarized on charts. In addition, there will be a display which is to cover the treatment of diabetic coma and the use of insulin mixtures in the control of diabetes.

* Denotes that this exhibit will feature special demonstrations each morning from 9:00–10:20 a. m., as well as during the afternoon recess.

S–33 THORACOPLASTY IN TUBERCULOSIS CONTROL
S–34

Wisconsin Anti-Tuberculosis Association

(The exhibit will be under the direction of A. A. Pleyte, M.D.)

Surgery in the treatment and control of tuberculosis occupies an important place. One of the most successful procedures is thoracoplasty. Physicians and surgeons particularly concerned with this phase of therapy in Wisconsin will combine efforts with the Wisconsin Anti-Tuberculosis Association to demonstrate the type of cases suitable for operation and results obtained (1) in terms of inactivity or an apparent arrest of the disease, (2) sputum and gastric negativity including negative gastric cultures, and (3) rehabilitation and number returned to work.

S–35 THE CORRELATION OF PHYSICAL AND CHEMICAL FACTORS IN THE PRODUCTION OF ARTERIOSCLEROSIS

Wisconsin Heart Association

The exhibit consists of a demonstration to illustrate the mechanism whereby physical and chemical factors, acting additively, produce the deposition and the characteristic reaction referred to as atherosclerosis.

S–36 LABORATORY AIDS TO DIAGNOSIS

National Foundation for Infantile Paralysis

The exhibit describes the spinal fluid examination for cell count and protein estimation. It also depicts the flocculation tests which may be of value in determining specific virus types. The experimental methods for isolation of virus in the laboratory are also shown.

S–37 CHEMOTHERAPY IN TUBERCULOSIS

Marquette University School of Medicine and Veterans Hospital, Wood

(The exhibit will be in charge of G. C. Owen, M.D. and his associates)

The exhibit will show the indications and contraindications for the use of streptomycin and dihydrostreptomycin in tuberculosis, using x-rays in illustrative cases. The role of para amino salicylic acid will be illustrated by graphs showing the effect of combined therapy (PAS with streptomycin) on the onset of streptomycin resistance. A small section will illustrate current bacteriologic methods of determining streptomycin resistance.

The effects of tebione (thiosemcarbasone) and especially the toxicity of this drug will be graphically represented.

The thesis will be stressed that antimicrobial therapy is most effective when used appropriately in conjunction with other conventional forms of therapy.

S–38 SCIATICA

Orthopedic Service, Veterans Hospital, Wood

The exhibit will center about an antatomic specimen to illustrate the subject of the exhibit. The purpose is to stress that sciatica is a symptom and not an entity, and that sciatical means herniated intervertebral disc until proven otherwise. The subject will be presented by a number of placards and photographs.

AT THE FOOT OF THE STAGE

The following scientific exhibits will be located at the north end of the exhibit hall, directly at the foot of the stage. It will be noted that the exhibit of Children's Hospital, Milwaukee, will feature a demonstration of interest to many practitioners. This demonstration will be held each morning.

SS–1 EARLY DIAGNOSIS OF CANCER IN SELECTED SITES
SS–2

SS–3 **Division of Cancer, State Board of Health**

The Wisconsin State Board of Health advocates, in a 30 foot exhibit, the early diagnosis of cancer. Selected body sites which afford ease of examination are presented: the breast, the uterus, the rectum, and head and neck locations. Aids to early diagnosis through symptomatology, practices, and laboratory assistance will be shown by photographs and colored slides.

SS–4 *BLOOD TRANSFUSIONS IN INFANTS

SS–5 **Milwaukee Children's Hospital**

(Exhibit under the direction of A. A. Schaefer, M.D.)

The exhibit will depict and demonstrate various routes and methods of giving transfusions to babies.

Technics of exchange transfusion for erythroblastosis fetalis will be shown on a manikin. The equipment necessary for efficient transfusion procedures will be on hand. A member of the staff of Milwaukee Children's Hospital will be present to demonstrate and to explain some of the problems.

Charts will be shown re indications, laboratory procedures such as typing and cross-matching, complications, and their treatment.

SS–6 GROSS TISSUE DEMONSTRATIONS

SS–7 **Wisconsin Society of Pathologists**

Autopsy and surgical specimens will be demonstrated by members of the Wisconsin Society of Pathologists. The effort will be made to furnish fresh tissues as far as possible, and the type of material will depend on what is available at the time of the meeting.

* Denotes that this exhibit will feature special demonstrations each morning from 9:00 to 10:20 a. m., as well as during the afternoon recess.

HOSTS FOR GUEST SPEAKERS

SPEAKER	HOST
A. B. Baker, Minneapolis	J. L. Garvey, Milwaukee
J. B. Brown, St. Louis	W. H. Frackelton, Milwaukee
Richard B. Cattell, Boston	C. S. Rife, Milwaukee
Jerome W. Conn, Ann Arbor, Mich.	Francis Rosenbaum, Milwaukee
Stuart C. Cullen, Iowa City, Iowa	J. W. Bookhamer, Milwaukee
Daniel C. Darrow, New Haven, Conn.	F. R. Janney, Milwaukee
Wm. F. Hughes, Chicago	F. H. Haessler, Milwaukee
Joseph A. Johnston, Detroit	F. J. Mellencamp, Milwaukee
Michael J. Jordan, New York City	T. D. Elbe, Thiensville
H. Dabney Kerr, Iowa City, Iowa	J. E. Habbe, Milwaukee
Yale Kneeland, Jr., New York City	Norman Osher, Milwaukee
Francis L. Lederer, Chicago	T. L. Tolan, Milwaukee
Hugh McCulloch, Chicago	Francis Rosenbaum, Milwaukee
Charles W. Mueller, New York City	J. F. Egan, La Crosse
Leo Rigler, Minneapolis	Irving Cowan, Milwaukee
W. D. Sutliff, Memphis, Tenn.	F. W. Madison, Milwaukee

"SMOKER" PROVIDES VARIETY OF ACTS

Those fortunate enough to secure seats at the 1949 Annual Meeting "Smoker" will recall the high grade of entertainment offered. A similar program is being arranged for the 1950 Annual Meeting, with the "Smoker" scheduled for Monday evening, October 2 from 8:30–10:00 in the Crystal Ballroom of the Hotel Schroeder.

Following custom, this feature of the program will be open only to members of the State Medical Society, guests, and exhibit representatives. *Wives of physicians are expected to attend the Auxiliary buffet supper in the Empire Room of the Hotel Schroeder.* Because of limited seating capacity in the Ballroom, members are asked to please *not* bring their wives if they do not choose to attend the Auxiliary meeting.

While the complete program for the "Smoker" will not be determined until a later date, the following features have been contracted for, and will provide the backbone for a program of outstanding merit.

Music by STEPHEN SWEDISH and His Band

RITA OEHMER, Chicago

Chanteuse Supreme—Artistry and Personality

LEE MONTES' TU-TONES, Chicago

Recording and Television Stars—Comedy and Music

These and other acts will constitute the evening program. It will be a meeting you will enjoy and one in which you can sit around and relax with your friends.

The hall can only accommodate 500 seated at the tables, so if you want a seat we suggest that you plan to be in the Ballroom by 8:30 sharp.

Reserve Your Rooms Early!

Hotel conditions are still crowded, so we urge you to make your reservations *early*. Rates of larger downtown hotels are given below. If you are unable to secure accommodations at the hotels listed, you may contact the Housing Bureau of the Milwaukee Chamber of Commerce.

Special Note to Delegates and Officers: The first session of the House of Delegates will be held on Sunday, October 1, so make your reservations accordingly.

Official Headquarters: Official headquarters are at the Hotel Schroeder, where luncheons and the Annual Dinner will also be held.

DOWNTOWN HOTEL ACCOMMODATIONS AND RATES

Name of Hotel		Single	Double	Twin Beds
MEDFORD	Without Bath	$2.25	$3.50 to $ 4.00	$4.50
	With Bath	$3.00 to $ 3.75	$4.25 to $ 5.25	$6.00 to $ 7.00
PFISTER	Without Bath	$3.00 to $ 4.50	$5.50 to $ 7.00	$5.50 to $ 7.00
	With Bath	$3.50 to $ 8.00	$6.50 to $10.00	$7.00 to $12.00
PLANKINTON HOUSE	Without Bath			
	With Bath	$4.00 to $ 6.00	$6.00 to $ 8.00	$7.00 to $10.00
RANDOLPH	Without Bath	$2.25	$3.50	
	With Bath	$3.00 to $ 3.25	$5.00 to $ 5.50	$6.00 to $ 6.50
SCHROEDER	Without Bath			
	With Bath	$3.75 to $10.00	$6.50 to $10.00	$8.00 to $12.00
WISCONSIN	Without Bath	$2.50 to $ 3.00	$3.75 to $ 4.75	
	With Bath	$3.50 to $ 7.50	$5.50 to $ 9.00	$7.50 to $10.00

Luncheon and Dinner Reservations

If you have not already done so, send in your luncheon and dinner reservations *today*. Many luncheons are already filled, so *be sure to list below* **three** *selections*, in order of preference, for each of the days you will be in attendance.

Mail to: C. H. CROWNHART, Secretary
State Medical Society of Wisconsin
704 East Gorham Street
Madison 3, Wisconsin

Cost of Luncheons: $2.00 per plate (Including gratuities)

Cost of Dinner : $4.00 per plate (Including gratuities)

Luncheon for MONDAY, OCTOBER 2

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Luncheon for TUESDAY, OCTOBER 3

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Luncheon for WEDNESDAY, OCTOBER 4

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Dinner— TUESDAY, OCTOBER 3

Reserve _____ places for me at $4.00 per plate.

Signed _____

Address _____

(*Make Your Check Payable to:* THE STATE MEDICAL SOCIETY OF WISCONSIN)

Preliminary Scientific Programs

THE WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

Hotel Schroeder, Sunday, October 1

PARLOR A, FOURTH FLOOR

2:00 p. m.: Business session and election of officers

3:00 p. m.: "A Survey of Anesthesia Practice in Denmark": Stuart C. Cullen, M. D., Associate Professor of Surgical Anesthesia, University of Iowa Medical School, Iowa City

5:00 p. m.: Social Hour

6:30 p. m.: Dinner

(All reservations for this meeting, and the dinner, should be directed to William Kreul, M. D., Secretary, Wisconsin Society of Anesthesiologists, Racine, Wisconsin.)

WISCONSIN CHAPTER OF AMERICAN COLLEGE OF CHEST PHYSICIANS

Hotel Schroeder, Sunday, October 1

CRYSTAL BALLROOM

No Registration Fee

1:00 p. m.: Registration: Crystal Ballroom
Scientific Exhibits

2:00 p. m.: Scientific Session, Crystal Ballroom

"Newer Concepts in the Management of Patients with Bronchial Asthma, Including Experience with ACTH and Cortisone": Maurice Segal, M. D., director, department of inhalational therapy, Boston City Hospital; assistant professor in medicine, Tufts College Medical School, Boston

"Roentgenologic Detection and Identification of Intracardiac Calcifications": J. Edwin Habbe, M. D., associate professor of radiology, Marquette University School of Medicine, Milwaukee

"Carcinoma of the Esophagus": Philip Thorek, M. D., associate professor of surgery, Cook County Graduate School of Medicine; assistant professor of clinical surgery, University of Illinois College of Medicine, Chicago

"Endogenous and Exogenous Pulmonary Edema": Elston L. Belknap, M. D., associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee

"Therapeutic Improvement of Symptoms in Emphysema": Edwin R. Levine, M. D., attending physician, Michael Reese Hospital; formerly director of chest service, Michael Reese Hospital, Chicago; adjunct professor of medicine, New York Medical College

"Cardiac Catheterization": Howard B. Burchell, M. D., consultant in medicine, Mayo Clinic, Rochester, Minn.; assistant professor of medicine, Mayo Foundation Graduate School, University of Minnesota, Minneapolis

6:00 p. m.: Dinner Meeting, Pere Marquette Room

"Roentgenologic Aspects of Mediastinal Diseases": Lester W. Paul, M. D., professor of radiology, University of Wisconsin Medical School, Madison

Practical Aspects of Anticoagulant Therapy*

By NELSON W. BARKER, M. D.
Rochester, Minn.

N. W. BARKER

Doctor Barker, head of a section in the division of medicine at the Mayo Clinic, received his medical degree from Rush Medical College in 1925. A diplomate of the American Board of Internal Medicine, he is a professor of medicine at the Mayo Foundation Graduate School of the University of Minnesota.

IN RECENT years anticoagulant therapy has developed into the most valuable medical procedure in the therapeutic attack on many different types of thromboembolic diseases. It must be admitted that this type of therapy has many shortcomings, is not very practical for use over long periods of time, is attended with some risk, and requires careful supervision. It must also be admitted that the only way that one can certainly prevent thrombosis by interfering with coagulation is to make the blood totally incoagulable. This is difficult and dangerous. For practical purposes anticoagulant therapy as carried out at the present time only attempts to inhibit the tendency to thrombosis by partially interfering with the coagulation mechanism. Under these circumstances, anticoagulant therapy may fail if the stimulus to thrombosis is too great. However, a considerable amount of clinical and statistical evidence has accumulated to show that, when properly given, anticoagulant therapy does prevent thrombosis and, therefore, embolism in almost all cases.

Each of the two anticoagulant drugs which are used has certain advantages and each has certain disadvantages. Heparin acts rapidly and its effect stops soon after administration is discontinued, but it is still expensive and time-consuming parenteral administration is required. Dicumarol acts slowly and its effect disappears slowly when administration is stopped. It is cheap and easily administered, but daily determinations of the prothrombin time, which are not always available to the general practitioner in a small community, are necessary if dicumarol is to be used safely and effectively.

An effective method of anticoagulant therapy is the combined use of heparin and dicumarol in which administration of each is started simultaneously. In this plan of therapy the heparin is used for one to three days and discontinued as soon as the optimal anticoagulant effect of the dicumarol is manifested. In Table 1 are listed conditions in which this plan of treatment has been used successfully. When used in these conditions, therapy should be started as soon as the diagnosis is made. For acute thrombophlebitis and pulmonary embolism the treatment is continued for a period of one to three weeks or as long as the patient remains in the hospital for either his primary condition or the vascular complication. Duration of treatment in congestive heart failure and polycythemia is dependent on the length of time required to bring the primary condition under control. The usual duration of treatment after acute myocardial infarction is four weeks, since at the end of this time the danger of secondary thromboembolic complications is greatly reduced.

TABLE 1.— *Conditions in Which Combined Use of Heparin and Dicumarol Has Been of Value*

1. Acute thrombophlebitis and/or pulmonary embolism occurring
   - *a.* after surgical operations
   - *b.* after childbirth
   - *c.* after severe injury
   - *d.* in congestive heart failure
   - *e.* in acute infectious diseases
   - *f.* in polycythemia vera
2. Acute myocardial infarction
3. Acute peripheral embolic or thrombotic arterial occlusion
4. After arterial surgical treatment when there is danger of subsequent thrombosis

Dicumarol alone has been used effectively as prophylaxis against thrombosis after operations, childbirth, or severe injury in cases in which the patient has had previous thromboembolic disease or in which the risk of thrombosis is considered great. Its administration is usually begun 48 hours after operation when prophylaxis is desired during the convalescent period and continued for 7 to 14 days or as long as the patient remains in the hospital. In recurrent idiopathic thrombophlebitis and/or pulmonary embolism and in chronic auricular fibrillation with intracardiac thrombosis, dicumarol has been used with apparent success over long periods of time but it is necessary that the patient be kept under close medical supervision. The seriousness of the prognosis justifies the difficulties with the therapeutic program in the cases of cardiac disease. In recurrent idiopathic thrombophlebitis, justification depends on the frequency of recurrences and the seriousness of the thromboembolic accidents.

There are a few situations in which it may be desirable to use heparin alone as an anticoagulant.

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

These include the conditions mentioned in table 1 if dicumarol therapy cannot be supervised adequately because accurate prothrombin times are not available, and in the conditions listed in table 1 if definite hepatic or renal insufficiency is present. The use of heparin alone may be advisable following some operations on the vascular system when immediate effect is desirable and it is desirable only to continue therapy for a few days.

Anticoagulant therapy has been used in some cases of cerebral arterial thrombosis and in some cases of thrombosis of retinal veins. There is still a hesitancy on the part of most clinicians who are experienced in anticoagulant therapy to use it routinely in cerebral thrombosis, because the diagnosis of the type of vascular accident may be difficult, there is insufficient evidence to indicate that further thrombosis can certainly be prevented, and there is no assurance that further damage to the brain will not occur as the result of minor bleeding into the infarcted area. To date an insufficient number of patients with cerebral arterial thrombosis and retinal vein thrombosis have been treated with anticoagulants to permit appraisal of the effectiveness of this type of treatment.

Contraindications to anticoagulant therapy have been mentioned in numerous previous reports. It is still generally agreed that neither heparin nor dicumarol should be used in the presence of purpuric states, blood dyscrasias with tendency to bleed, subacute bacterial endocarditis, and in cases in which there has been recent operation on the brain or spinal cord. Dicumarol, but not heparin, is contraindicated in the presence of definite hepatic or renal insufficiency. In addition, patients who have ulcerative lesions, particularly of the gastrointestinal tract, are increased risks for bleeding when anticoagulant therapy is used even when excessive effects are avoided. In such situations the risk of serious or fatal thromboembolic accidents must be balanced against the risk of serious bleeding. There is increased risk of bleeding if anticoagulant therapy is begun within two days after surgical operation, childbirth, or serious injury. Also, if there are open surgical wounds, drainage tubes in wounds, indwelling catheters, or other tubes in body orifices, anticoagulant therapy increases the tendency to bleed from the wound or tissues around the tube. If anticoagulant therapy is strongly indicated in such patients, more than the usual amount of caution as well as frequent examinations and observation of the patient for signs of bleeding are required. Patients in poor states of nutrition, particularly those with gastrointestinal disease or recent gastrointestinal operation, have a somewhat greater tendency to bleed during anticoagulant therapy and their coagulant mechanism may be more easily upset by the usual therapeutic doses of the anticoagulants. At therapeutic levels the anticoagulant effect of heparin is just as conducive as the anticoagulant effect of dicumarol, if not more so, to the development of bleeding from ulcers, recent surgical wounds, or granulation tissue. The only advantage of heparin over dicumarol in this regard is that if serious bleeding does ensue, the effect of the anticoagulant can be stopped more quickly.

In the use of anticoagulants the possibility of serious bleeding should always be kept in mind, but actually the risk is small if the contraindications and factors which favor bleeding are kept in mind and if care is taken to keep the effect of dicumarol within the therapeutic range. Minor bleeding such as microscopic hematuria, mild epistaxis, small hematomas in wounds, and ecchymosis at the site of needle punctures can usually be disregarded and is not an indication to stop therapy. At the Mayo Clinic the incidence of serious bleeding during dicumarol therapy in the postoperative period has been approximately 3 per cent in patients who have not had thrombosis and approximately 1 per cent in patients who have had thrombosis. The incidence of fatal bleeding that could be attributed to dicumarol has been less than 0.1 per cent. In more than 100 successive patients with acute myocardial infarction treated with anticoagulants we have not encountered an instance of serious bleeding. If serious bleeding occurs anticoagulant therapy should be stopped. If intravenous heparin alone has been used, the coagulation time will return to normal quickly. If dicumarol has been used, synthetic vitamin K in large doses should be given every six hours until bleeding stops. The effectiveness of synthetic vitamin K in such cases has been questioned recently. If a human being or an animal is deliberately given large doses of dicumarol every day until the prothrombin is forced below 5 per cent and kept there several days or weeks the effect of synthetic vitamin K is doubtful. However if the prothrombin deficiency has only been pushed into the therapeutic range or if the patient has reacted excessively to small or average doses of dicumarol, synthetic vitamin K is almost always effective and the prothrombin time will drop to safe levels almost always within 18 hours and sometimes in six hours after it is given. If blood loss during anticoagulant therapy is sufficient to cause alarm, transfusions of blood should be given. The effect of transfusion in reducing the prothrombin time is transient and of doubtful value, and the real purpose is to replace lost blood. Transfusion should be repeated as necessary until bleeding stops.

The first method of administration of heparin was to give it continuously intravenously in dilute solution regulating the number of drops per minute so that the coagulation time of venous blood was maintained between 15 and 25 minutes. This continous administration is well tolerated by patients for periods as long as 10 days and theoretically is still the most effective and safe method, but it has largely been abandoned because of necessity for frequent coagulation time tests (at 12 hour intervals or less) and close observation of apparatus to keep the drops delivered per minute at the desired number. The method of administration which is most widely used is the intermittent intravenous injection of a fixed dose usually of 50 to 100 mg. every

four hours. This is apparently effective, although admittedly there is no measurable effect on the coagulation mechanism for at least one to two hours out of each four and the method disregards differences in heparin tolerance which are known to exist among different patients. At the present time there is lack of agreement concerning the advisability of administration of heparin subcutaneously or intramuscularly in a slowly absorbed medium. This method is the simplest, requiring only one injection in 24 hours (some say 48 hours). Solutions have been improved, so that pain at the injection site should not occur. However, heparin is not less expensive when given this way, and again differences in heparin tolerance are disregarded in determining dosage. Most detailed studies of duration and degree of effect of heparin on coagulation time have been made in normal persons. Several studies have shown that most patients with recent intravascular thrombosis have increased tolerance to heparin with less immediate increase in coagulation time and a shorter duration of measurable effect than occurs in normal persons. In a few cases the reverse is true. Several studies by different investigators have shown that the effect of 400 mg. of heparin given subcutaneously to each of a group of patients with intravascular thrombosis produced variable and unpredictable effects of variable and unpredictable duration. In many cases the effect lasted less than 12 hours. In a few cases there were periods when excessive prolongation of coagulation time up to 60 or 90 minutes occurred. Of course, it is possible that an antithrombotic effect may be produced by heparin which is not measurable by the ordinary coagulation time test, but there is no evidence to favor such a concept. If a fixed dose, such as 400 mg., is used for each patient, it is probable that there will be long periods in each 24 hours when there is no protective anticoagulant effect, and it is possible that there may be periods of excessive effect with danger of bleeding which will be more difficult to control than if the heparin had been given intravenously. It seems reasonable that some sort of heparin tolerance test should be done to determine dosage of subcutaneously administered heparin and it is probable that doses larger than 400 mg. will have to be given to many patients if adequate anticoagulant effect is to be obtained.

In order to produce optimal anticoagulant effect the dosage schedule of dicumarol must be individualized for each patient. The one stage prothrombin time test (Quick) is still the key to dicumarol therapy and it is unwise and unsafe to use dicumarol at all unless this test can be done daily. In spite of efforts at standardization of the test the different types of thromboplastin and different methods of preparing thromboplastin which are used in different clinics and institutions throughout the country still make discussion of optimal degrees of prothrombin deficiency difficult, since prothrombin times in seconds are not comparable in different institutions. The following plan can be carried out with the cooperation of any physician and any laboratory where the prothrombin time test is done, regardless of the source and method of preparation of the thromboplastin. Each time a new batch of thromboplastin is prepared, T^{30}, T^{20} and T^{10} should be determined.

T^{30} = average prothrombin time, in seconds, of 30 per cent plasma in 0.9 per cent sodium chloride solution from 3 normal persons.

T^{20} = average prothrombin time, in seconds, of 20 per cent plasma in 0.9 per cent sodium chloride solution from 3 normal persons.

T^{10} = average prothrombin time, in seconds, of 10 per cent plasma in 0.9 per cent sodium chloride solution from 3 normal persons.

The prothrombin time, in seconds, should be kept between T^{30} and T^{10}.

Three hundred milligrams of dicumarol are given on the first day and 100 mg. on each subsequent day that the prothrombin time is less than T^{20}. No dicumarol is given on days when the prothrombin time is greater than T^{20}. If the patient is found to be resistant to the drug, the dose is increased to 200 mg. on each day that prothrombin time is less than T^{20}. If the prothrombin time is greater than T^{10} on two successive days, 30 mg. of menadione bisulfite are given intravenously.

Dr. E. S. Nichol, of Miami, Florida, has suggested a somewhat simpler formula based on his observation that in a number of institutions the optimal level or theraupeutic range of prothrombin deficiency for dicumarol therapy was expressed by a prothrombin time between two and two and a half times the normal prothrombin time in seconds. In using Nichol's formula, the normal prothrombin time should be determined each day by taking the average of results obtained by testing 2 or more normal individuals who were not receiving anticoagulants and this normal should be less than 20 seconds. Three hundred milligrams of dicumarol are given the first day and 100 mg. on each subsequent day until the prothrombin time is greater than twice the normal time in seconds for that day. Then 75 mg. are given each day if the prothrombin time is in the therapeutic range (between two and two and a half times normal). If the prothrombin time goes above the therapeutic range, doses are omitted until it returns to the therapeutic range and then continued at the rate of 50 mg. a day. If with 75 mg. a day the prothrombin time drops below the therapeutic range, the dose is increased to 100 mg. a day. Further observation may indicate that variations in dosage of 25 mg. on certain days may be necessary in some patients to keep the prothrombin time within the therapeutic range.

Long time anticoagulant therapy with dicumarol continued for months has been used successfully in coronary thrombosis, chronic auricular fibrillation with intracardiac thrombosis and recurrent idiopathic thrombophlebitis. For long time dicumarol therapy the daily dose which will keep the prothrombin time in the therapeutic range is established as soon as

possible and the patient is kept on that dose for two or three weeks. If no sudden variations in the daily prothrombin time occur, the frequency of prothrombin time determinations is gradually reduced to once a week but during the entire period of therapy the tests should be done once a week at least and oftener if there is any irregularity in response.

Finally I think it can be stated fairly that anticoagulant therapy has saved many lives and prevented much disability. When properly given the risk of bleeding is small and not greater than the risk of serious untoward effects which is assumed for many medical and surgical procedures of accepted therapeutic value. Anticoagulant therapy requires careful supervision and individualization because the quantitative response cannot be predicted in advance and the margin of safety between a therapeutic effect and a potentially dangerous effect is small.

AMERICAN UROLOGICAL ASSOCIATION OFFERS ANNUAL AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Palmer House, Chicago, May 21–24, 1951.

Full particulars may be obtained from the secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 10, 1951.

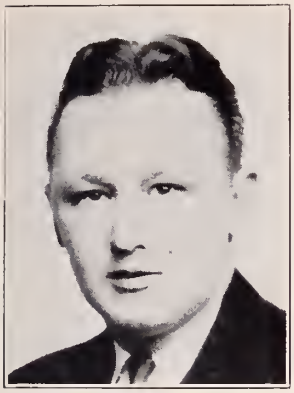
UNIVERSITY OF MINNESOTA ANNOUNCES CONTINUATION COURSE ON INFERTILITY

Female and male infertility will be the subject of the continuation course to be presented by the University of Minnesota on September 28–30. The course, intended for physicians specializing in obstetrics and gynecology, will be presented at the Center for Continuation Study. Distinguished visiting physicians who will participate as faculty members will include Dr. Warren O. Nelson, University of Iowa College of Medicine; Dr. Isador G. Rubin, Mount Sinai Hospital and New York University College of Medicine; and Dr. Fred A. Simmons, Harvard University Medical School. Staff members of the University of Minnesota and the Mayo Foundation will complete the faculty for the course.

Key topics which will be discussed during the three day course include psychosomatic aspects of sterility, the investigation and management of the infertile couple, the management of amenorrhea, and artificial insemination.

Complications of Pregnancy*

By CARLTON WIRTHWEIN, M. D.
Milwaukee



CARLTON WIRTHWEIN

Doctor Wirthwein maintains a private practice in Milwaukee and serves as assistant clinical instructor of obstetrics and gynecology at Marquette University School of Medicine. A diplomate of the American Board of Obstetrics and Gynecology, he received his medical degree from Marquette in 1935.

THIS discussion of fetal pelvic disproportion is presented not because it is unusual but rather because, in contradistinction to the old and untrue dictum of "once a cesarean, always a cesarean", it is frequently assumed that a patient who has been delivered vaginally will again deliver via the same route, and easily.

That this assumption confirms to some extent our teaching is evidenced by the disregard which delivery room personnel have for a multipara in active labor with an unengaged presenting part, merely because the patient has had a baby before.

Fetal pelvic disproportion should be recognized immediately upon the patient's entrance to the hospital, if not before, since fetal mortality is very low in cases in which spontaneous delivery occurs in conjunction with contracted pelvis, but very high in those in which a trial of labor goes on to 30 hours or more. How long a trial of labor should be allowed depends not on time in hours, but rather upon an evaluation of both x-ray pelvimetry and clinical judgment in the individual case.

Since the intern staff, usually least experienced in obstetrics, is the first to be confronted with the case, we should stress upon them the importance of unengagement of the presenting part in a patient near term or in active labor. One can evaluate the importance of unengagement only by an accurate and complete history, a study of the x-ray measurement of pelvic capacity, and observation of the uterine force.

In considering the treatment of borderline cases of contracted pelvis, it would seem that the antibiotics, availability of blood transfusion, and improved operative technics have made cesarean section the precedure of choice when real doubt exists.

That doubt exists frequently and that disproportion presents the obstetrician with a most troublesome problem, especially when it occurs in a multipara, can be substantiated by a review of cesarean statistics as well as a résumé of cases in which forceps failed. Such a report by Daichman and Pomerance, concerning 55 cases at the Jewish Hospital in Brooklyn and reported in the September 1948 *American Journal of Obstetrics and Gynecology*, showed the following:

Parity Primiparas 35
Multiparas 20
Fetal Mortality Total fetal mortality—36.3 per cent.
Fetal mortality in the 13 true disproportion cases 76.8 per cent.
Maternal mortality 1, or 1.8 per cent.
Average Labor 32.2 hours
Primiparas—42.2 hours
Multiparas—15.3 hours
Average Ruptured Membranes—28.7 hours.

In attempting to lower the fetal mortality in similar cases and at the same time keep our cesarean rate at a sensible level, what can we as attendants do to help bring this about? Perhaps the following criteria can be helpful to us in determining which of our patients should be given the advantage of x-ray pelvimetry as well as alerting us to allow a cautious but not injudicious trial of labor when fetal pelvic disproportion might exist:

I. History in multiparas, especially	A. Previous difficult prolonged labor and especially mid-forcep delivery B. Unexplained stillbirth
II. Palpation	A. Prominent ischial spinae B. Sacral deformity
III. Measurement on estimation of pelvic capacity	A. At inlet—ability to touch sacral promontory on vaginal examination B. External measurements below average C. Outlet—Bi-ischial diameter 8.5 cm. or less, and wherever the sum of the bi-ischial and posterior sagittal diameters is 15 cm. or less.

IV. In primipara—Non-engagement of the fetal head at term

As outlined by Mengert, the five components of fetal pelvic disproportion depend upon, first, size and shape of the bony pelvis; second, size of the fetal head; third, moldability of the head; fourth, the force exerted by the uterus; and fifth, presentation and position.

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

Next to pelvic size, perhaps the most important component affecting the outcome of labor is the driving force of the uterus.

Considering all factors, a trial labor usually enables one to foretell satisfactorily whether or not a spontaneous outcome can be expected. However, a fair trial in many instances cannot take place until after the fetal membranes are ruptured and the fetal head has become adjusted to the pelvic brim, because in many cases the labor is hesitant or mild in the first few hours. A reevaluation from two to six hours after the rupture of membranes and examination to confirm position and altitude of the head, the degree of descent into the pelvis, quality of the fetal heart, and the type and frequency of uterine contractions should enable one to arrive at the best solution for management of each case.

In conclusion, with apology to McCormick "We should seek to determine not what a woman can endure, but what she can accomplish."

UNITED STATES CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS TO MEET IN CLEVELAND

The fifteenth annual assembly of the United States Chapter of the International College of Surgeons will be held in Cleveland, Ohio, October 31 to November 3, with headquarters at the Cleveland Hotel.

Surgical clinics will be held in several Cleveland hospitals on Monday, October 30. All scientific sessions will be held at the Cleveland Public Auditorium 9:00 a. m. to 5:00 p. m. Tuesday through Friday. A most excellent program has been arranged, at which time some of the most prominent surgeons of America, and some foreign speakers, will discuss the current contemporary surgical scene.

Through the courtesy of Smith, Kline and French Laboratories, a colored television program of surgical procedures, originating from the St. Vincent's Charity Hospital, Cleveland, will be shown daily in the auditorium from 9:00 a. m. to 1:00 p. m. Motion pictures will also be presented each day depicting many of the recent advances in surgery and surgical technic.

One of the high lights of the meeting will be the annual banquet at the Statler Hotel on Thursday evening, when Dr. Frank Lahey of Boston, will talk on "Some of the Recent Advances in Surgery." Dr. Elmer Henderson, president of the American Medical Association, will deliver an address on "The Importance of International Cooperation in Surgery."

Reservations may be secured by writing to the Committee on Hotels, International College of Surgeons, 511 Terminal Tower, Cleveland 13, Ohio. Preliminary programs may be obtained from the central office, 1516 Lake Shore Drive, Chicago 10.

X-RAY TECHNICIANS TO MEET IN MADISON

The Wisconsin Society of X-ray Technicians is holding its annual convention at the Loraine Hotel in Madison on September 8 and 9. An interesting and educational program has been arranged.

An exhibit of films taken by Wisconsin technicians won first prize at the convention of the National Society of X-ray Technicians held in Columbus, Ohio, in May of this year. Willard Larson, R. T., of Columbia Hospital, Milwaukee, won the individual award. Everyone is urged to see this exhibit during the coming state convention. It is hoped that each radiologist in the state will allow his technicians to attend.

For further information contact Stan Dixon, R. T., 905 University Ave., Madison, Wisconsin.

A Critical Appraisal of the Present Status of "Rh Hapten"*

By TIBOR J. GREENWALT, M. D.
Milwaukee

T. J. GREENWALT

Doctor Greenwalt was graduated from the New York University College of Medicine in 1937. A diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians and the International Society of Hematology, he is the medical director of the Junior League Blood Center of Milwaukee, clinical instructor in medicine at Marquette University School of Medicine, and is on the staffs of Veterans Hospital, Wood, and Mount Sinai and Milwaukee County Emergency hospitals.

THE term "hapten" designates the specific reacting portion of any antigen. Naturally occurring antigens consist of two parts. One is a protein which is essential for stimulating the formation of antibodies. The other is a substance (hapten), usually of lipo-carbohydrate nature, which reacts with its specific antibodies in vitro, but its capacity to immunize is inconsiderable as compared with its binding power.[1] If the haptenic portion of the Rh antigen could be separated from its protein, then conceivably it might be possible to use it to neutralize the anti-Rh antibodies produced antenatally without the hazard of stimulating the production of more. The fetus would be protected because the damaging antibodies would be neutralized before they reached it.

In 1947 Carter[2] reported the successful production of a crude hapten extract from pooled, outdated Rh-positive blood bank red cells. Goldsmith[3, 4] and Price[5, 6] have reported the production of similar extracts using slight modifications of Carter's procedure. These extracts are supposed to possess specific complement fixing activity in vitro. Carter[7, 8, 9] and Goldsmith[3, 4] have published encouraging reports of their clinical experiences with these materials.

We have used "hapten" for the past 11 months. A portion of the material used was prepared by a method modified from the procedures described by Carter, Price, and Goldsmith. The remainder of the material was produced in the laboratories of Eli Lilly and Company.† The treatment was administered as recommended by Carter and Goldsmith. Two hundred to 400 mg. of the extract were injected intramuscularly at one to two weekly intervals, starting as early in pregnancy as possible.

Our product has shown in vitro complement-fixing activity in dilutions as high as 1:20,000, but presumably inactive material prepared from rh-negative cells has shown similar activity, demonstrating the nonspecificity of this reaction.

Twenty-six pregnancies have been followed to completion under "hapten" treatment. Eleven of the patients delivered living Rh-positive infants. Four of these required no treatment; 3 survived after multiple transfusions, and 4 after replacement transfusion. There were nine stillbirths and two abortions. The remaining 4 infants were rh-negative. These results are not very encouraging, but it might be said that treatment was started too late, i.e., after the first trimester of pregnancy. If we tabulate our results on the basis of the period of pregnancy when treatment was started rather than the number of injections given, the results are even more discouraging. In 11 cases in which treatment was started before the fourth month of pregnancy, 1 infant survived after multiple transfusions and 1 after replacement transfusion. There were seven stillbirths and two abortions.

Discussion

One must be circumspect in evaluating the results of therapy in any condition with a course as unpredictable as that of erythroblastosis fetalis. It has been stated that the outcome of pregnancy in an isoimmunized woman can be fairly accurately predicted on the basis of the type and titer of the antibody demonstrable during the prenatal period. Analysis of completed data on 74 pregnancies in isoimmunized women indicates that, while severely involved infants and stillbirths are more frequent in patients with albumin acting (blocking) antibodies in titers of 1:16 and over, there are too many exceptions to make accurate statistical prognostication feasible in any individual situation. Severely involved infants were delivered of women with lower titers, and occasionally mildly involved infants occurred in cases of women with higher titers. A previously isoimmunized woman whose titer rose to 1:128 in albumin delivered an rh-negative infant.

The classic pattern of progressive severity of involvement with each succeeding pregnancy is by no means constant. East and Mair[10] recently reported a very interesting case which will serve to exemplify this point. The patient was given a transfusion of 500 cc. of her husband's blood for hem-

* Presented before the One Hundred Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

† Supplied through the courtesy of Dr. J. E. Maas, Medical Director, Eli Lilly & Company.

orrhage complicating an abortion in October 1940. In 1942 she gave birth to a moderately jaundiced child, which survived. In 1945 she had a spontaneous abortion at eight weeks. In 1946 she had a macerated stillborn child. The authors gave the patient 28 intravenous and 43 intramuscular injections of her husband's blood* in an attempt to desensitize her. The mother's titer was 1:4,000 in albumin at the time of delivery. The infant was only moderately involved and survived after multiple transfusions.

Normal Rh-positive babies born to sensitized women occur not infrequently without any intervention. This has not been sufficiently stressed in the literature. Sacks[11] reported that 33 per cent of the infants in his series of 79 did not have hemolytic disease. He explains this by stating that the antibody titer was not sufficiently high to cause trouble. Frisch and Jackets[12] mention 8 normal Rh-positive infants born to mothers with low titers. Dockeray and Sachs,[13] Kariher and Miller,[14] Goldbloom and Lubinski,[15] and Howard, Lucia, Hunt, and Talbot[16, 17] reported 78 additional cases, making a total of 136 which I have been able to find in the literature.

It would seem that if Rh hapten had any activity at all, it would at least be possible to clear the blood stream of "carry over" antibodies during an rh-negative pregnancy. Surprisingly enough even this was not accomplished in our patients having significant anti-Rh titers and bearing rh-negative infants.

Conclusions

1. The extracts being produced with our present methods probably do not contain true Rh hapten.
2. Our experience indicates that "Rh hapten" as it is prepared and administered at present is of no clinical value in protecting the fetus from maternal antibodies.

Addendum

The author has now completed the treatment of 20 additional patients, making the total 46. In many of the more recent cases the patients were treated much more intensively than the group presented here. His conclusions remain unchanged.

* The patient is a doctor's wife. We do not advocate this method of treatment.

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JACKSON CLINIC ANNOUNCES POSTGRADUATE CLINIC PROGRAM

The annual postgraduate clinic presented by members of the faculty of the Marquette University School of Medicine and the staff of Jackson Clinic will be held on September 30, the day of the Wisconsin–Marquette football game. A scientific program will be followed by luncheon at the Loraine Hotel, Madison, for the doctors and their wives, following which they will attend the game.

8:30 Registration
9:00 Management of the Irritable Colon—Dr. Robert A. Straughn, Jackson Clinic
9:20 Tumors and Cysts of the Neck—Dr. Arnold S. Jackson, Jackson Clinic
9:50 Uncommon Portals of Entry in Poliomyelitis—Dr. Max Fox, Milwaukee
10:20 Management of Prolonged Labor—Dr. Robert McDonald, Milwaukee
10:50 Surgical Emergencies in Children—Dr. Arthur Schaefer, Milwaukee
11:20 Excision of Giant Panniculus Adiposus (Motion Picture)—Dr. James A. Jackson and Dr. John R. Steeper, Jackson Clinic

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Therapeutic Bed Rest

A careful experimental study of the role of therapeutic bed rest and cardiovascular performance has recently been reported by Taylor and associates[1] of the University of Minnesota. Plainly, the problem concerns the effects of complete bed rest of three weeks' duration as a basis for the balancing of merits and demerits relative to early ambulation as in cases of selected patients.

The subjects of the experimentation were 6 young men without significant physical defects who were maintained continuously in the laboratory under very careful control of diet, rest, and activity. They were subjected to a period of physical conditioning followed by three weeks of complete bed rest, then six weeks of reconditioning. An extensive set of tests was performed to determine quantitatively what changes, if any, occurred in the various physiologic systems.

It was found that the most striking change produced by extended bed rest occurred in the cardiovascular system. This change was decisively in the nature of inefficiency. Uptake of oxygen was reduced by about 16 per cent at the end of the rest period and recovery to normal required from three to five weeks, a time more or less proportional to the duration of the complete bed rest. The resting heart rate decreased in complete bed rest to increase rather markedly after resumption of physical activity. These features indicate that there is a physiologic basis for the general weakness induced by prolonged bed rest. One suspects that dizziness and "lightheadedness" on rising from the sickbed, often formerly complained of, can be interpreted at least as a temporary cardiovascular inadequacy.

The empirically employed and perhaps entirely justified complete bed rest in pulmonary tuberculosis would appear to be based on the assumed necessity of pulmonary quiescence for purposes of allowing the development of fibrous tissue for the walling off of foci of infection. One may add that it is generally accepted that the most common sites of pulmonary tuberculosis are in the apices, and this because of the lessened blood flow in these areas when the individuals are in the upright position. Conceivably, however, an increased blood flow in the apices, due to bed rest, might even favor a spread of the infection as against the hoped-for benefits of an increased supply of blood.

In acute cardiac accidents, such as coronary obstruction, less work demand on the heart may reduce the probabilities of rupture through the weakened areas of infarction, at least before sclerosis into stronger inelastic fibrous tissues has had time to develop.

While certain and even disturbing evidences referable to the physical effects of complete bed rest are becoming available, there is little known as to what occurs in respect to immunologic capacities. To date, it is not certain that a slowed heart rate, a reduced oxygen uptake, and a lowered blood pressure contribute to the formation of antibodies or any other of the immunologic processes. Is resistance to disease increased or decreased? It has long been assumed that bed rest is a condition favorable to such emergencies, but in view of reduced cardiovascular capacity, one questions whether or not such precautions may be, in reality, added liabilities. One awaits clearcut evidence and, in the meantime, continues with customary procedures.

In the field of postoperative effects of early ambulation, much has been learned in recent years, lessons that now are fairly clearly evident from postoperative care of both adults and small children. Small children do not lightly submit to admonitions such as: "Stay quiet in order to avoid complications and to get well quickly!" They may get well quickly but the quietude part of the injunction is quite another matter.

The argument may be advanced that in fevers there is apt to occur a "negative nitrogen balance," but is this, in itself, a serious matter if of relatively short duration? Bed rest itself may well lead to a reduction of the rate of loss of nitrogen. By contrast, a positive calcium balance may add to the possibility of serious ossification.

The relatively near future may see the development of a sounder understanding relative to bed rest versus moderate exercise and ambulation in the care of the acute and chronically ill.—A. L. TATUM, M. D.

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Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Quantitative Determination of Serum Bilirubin with the Ducci and Watson Modification of the Malloy and Evelyn Method

Reagents

1. *Ehrlich's diazo reagent.*—This reagent is made of two solutions. The final mixture must be freshly prepared prior to the test.

   (a) Solution A. Dissolve 1.0 Gm. of sulfanilic acid in 15 cc. of concentrated hydrochloric acid, and dilute to 1,000 cc. with distilled water. Mix well.

   (b) Solution B. Sodium nitrite 0.5 Gms.; distilled water to make 100 cc. Store in a brown glass bottle in the refrigerator. Discard if the solution shows any yellow tint or mold. (Keeps for about two months).

   (c) Final mixture diazo reagent. Solution B, 0.3 cc.; solution A, 10 cc.

2. *Absolute methyl alcohol.*

3. *Diazo blank solution.*—Add 15 cc. of concentrated hydrochloric to distilled water and dilute to 1,000 cc. with distilled water. This is a stable solution.

Procedure

1. In a cuvette dilute 1 cc. of clear, unhemolyzed serum or plasma (not more than two hours old) to 10 cc. with distilled water. The specimen should be collected in the post-absorptive state to avoid the turbidity of alimentary lipemia. (Highly colored serum or plasma requires larger dilution. Calculations are adjusted accordingly after the results of the test have been read).

2. Remove 5 cc. of the diluted specimen with a volumetric pipette and place it in a second cuvette. Label the one cuvette "blank" and the other "test."

3. To the "blank" add 1 cc. of *diazo blank solution.* Mix gently and place in the spectrophotometer with a wave-length setting of 530 millimicrons or with a corresponding filter in place in a photometer. Set the blank at 100 per cent transmittance (galvanometer reading at 100).

4. To the "*test*" add 1 cc. of the *final mixture diazo reagent* and mix gently. Time immediately when the reagents are mixed. Read transmittance after exactly one minute. Record as milligrams per cent of direct reacting bilirubin.

5. Add 6 cc. of absolute methyl alcohol to both the "blank" and the "test" and mix gently. Read the test against the blank after 30 minutes and record the milligrams per cent of total bilirubin. (Some workers make the reading after 15 minutes. It should be noted, however, that the color is stable for 30 minutes).

When the color is too deep and the galvanometer reading falls below 10, it is best to dilute both the "*blank*" and the "*test*" with 50 per cent methyl alcohol and to correct the reading for the further dilution. (*Example.* The addition of 12 cc. of alcohol requires multiplication of answer by 2).

6. Indirect reacting bilirubin is the difference between the total and the direct.

Preparation of Standard Curve for Spectrophotometer or Filter Photometer

1. *Solutions.*—
   A. Stock bilirubin solution. Weigh accurately 10 mg. of pulverized bilirubin and dissolve in chloroform using a 100 cc. volumetric flask. Dilute to volume and mix well. Store in a well stoppered dark bottle in the refrigerator. This solution is stable. Each cubic centimeter of the solution contains 0.1 mg. of bilirubin.
   B. Working bilirubin solution. Dilute the stock solution of bilirubin 1 to 10 with methyl alcohol. Mix well. This solution is unstable. Discard any unused portion. Each cubic centimeter of solution contains 0.01 mg. of bilirubin.

2. *Calibration procedure.*—
   A. Into five cuvettes pipette 0.5, 1, 2, 3, and 4 cc. of the working bilirubin solutions. Add 1 cc. of diazo reagent and enough methyl alcohol to make the final volume of 6 cc. The amounts prepared are equivalent to 1, 2, 4, 6, and 8 mg. of *direct reacting bilirubin* per hundred cubic centimeters of blood, respectively and to 2, 4, 8, 12, and 16 mg. of *total* bilirubin, respectively.
   B. Prepare a blank tube with 1 cc. of the diazo blank and 5 cc. of methyl alcohol.
   C. After allowing 30 minutes for color development (some allow only 15 minutes), set the galvanometer at 100 with the blank and take the readings of the standards.
   D. Plot the readings on semi-log paper. Draw a straight line from the 100 per cent point through the points obtained.
   E. Concentration of unknowns may now be read directly by reference to the calibration curve or from a table prepared from the curve.

W. H. JAESCHKE, M. D., *University of Wisconsin.*

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See next issue of this *Journal* for interpretation of values and a summary of the Ducci and Watson serum bilirubin test.

THE MEDICAL FORUM

SOCIETY DISABILITY PROGRAM IN EFFECT AUGUST 15

Blue Shield (WPS) to Move to Madison

Madison, Aug. 1.—The offices of the Blue Shield Plan of the State Medical Society of Wisconsin (formerly Wisconsin Physicians Service) will be moved to Madison on October 1 to occupy space in the medical society headquarters.

This move, authorized by the Council on June 4–5, brings all agencies of the state medical society together in one building. Since 1946, the Blue Shield Plan has been housed with Associated Hospital Service, Inc., (Blue Cross) in Milwaukee.

Blue Shield will occupy the entire third floor of the headquarters building. Mr. Ralph F. Weber, executive director, will continue in his office on the second floor.

Physicians Asked to Aid Nursing Survey

Madison, Aug. 5.—An extensive survey to determine the number of nurses in Wisconsin, and where they are practicing, is being conducted by the Wisconsin State Department of Nursing, according to Adele G. Stahl, R. N., director.

Already completed is the survey of hospitals, industrial firms and medical clinics. Each has reported the names of all nurses employed by them. Miss Stahl said that a survey of all physicians will begin within the next two months.

Physicians will be asked to list all nurses employed by them in any capacity.

Wisconsin statutes provide that no one may practice as a graduate, registered, trained or certified nurse unless registered with the department. Miss Stahl declared that the survey will help the department carry out its legal responsibility, but emphasized that the reports sent to the department "will in no way be reflected on their employment as nurses."

"Some doctors think that they have a registered nurse working for them and our survey uncovers the fact that they are not licensed in this state," Miss Stahl said. She warned that such a state could "materially increase the doctor's danger of malpractice suits."

Information obtained from the survey concerning registered nurses, trained practical nurses, undergraduates and unlicensed nurses will be correlated and employers notified if the nurse's status is not in conformance with the law.

No action will be taken against the nurse, Miss Stahl said. She stressed the fact that the survey is part of an educational program to insure that all nurses practicing in the state are registered and qualified.

Doctors May Enroll to Sept. 15; Considered "Best Buy" in Field

Attention, Doctor!!!!

YOU are cordially invited, and urged, to attend the 1950 Wisconsin Rural Health Conference. It is the result of much effort on the part of the Committee on Rural Health of the State Medical Society in bringing together nearly 50 organizations interested in this problem.

Farm people from every corner of the state will attend to discuss their health problems. Their problems are also your problems. Plan now to attend.

Total cost of the two day conference is $6.50, including banquet, breakfast and lunch, overnight room at the lodge, and registration fee.

To facilitate planning, please notify the State Medical Society of Wisconsin, 1950 Rural Health Conference, 704 E. Gorham Street, Madison, of your intentions to attend.

Details of the program are found on pages 718 and 719 of the Forum.

Madison, Aug. 16.—The state medical society-sponsored sickness and accident insurance program (disability insurance) went into effect on August 15, reported Dr. Maurice Hardgrove, Milwaukee, chairman of the society's committee to study group insurance.

Dr. Hardgrove reported that a majority of the members of the society had enrolled in the plan permitting the underwriting company to place the program into effect.

Maurice Hardgrove

Any member of the medical society who has not already done so may enroll any time before September 15, according to Dr. Hardgrove.

After September 15 anyone previously eligible to enroll will be required to declare pre-existing conditions.

The society's program was selected after a study of more than two years and a large number of insurance policies. The plan adopted by the medical society, and currently available to all members on a group basis, is thought to be "one of the most outstanding of its kind in the nation."

Dr. Hardgrove declared that the plan is "definitely the best buy" in the field. He urged all physicians to give it immediate consideration.

AMA SAYS A.S.T.P. AND V-12 DOCTORS FIRST IN DRAFT

Chicago, Aug. 3.—The Council on National Emergency Medical Service of the American Medical Association today expressed its support of legislation, if necessary, to provide for the military call on a priority schedule of physicians needed for national defense.

The Council's chairman is Dr. J. C. Sargent, Milwaukee.

Recommends Call of Non-Veterans

The council's recommendation, submitted to the A.M.A. Board of Trustees for approval, placed emphasis on the first call of the nearly 8,000 non-veteran physicians who received training at government expense during and since World War II and of all others who were deferred in order to complete their medical studies.

The recommendation was based on the understanding that an appropriate body be established in government to effect certain measures relative to the utilization of physicians by the medical departments of the Armed Forces.

These measures are:

(1) That the induction of physicians into the Armed Forces be kept to the minimum needed to provide adequate medical service to the personnel of these forces.

(2) That appropriate consideration be given to current and potential needs of the civilian population for medical services.

(3) That in calling civilian physicians, including reserve officers, for military service the following priorities be observed:

(a) Those physicians who were permitted to pursue their medical educations during World War II and who did not serve as medical officers.

(b) Those physicians who were below the Selective Service age during World War II.

(c) Those physicians who graduated prior to World War II but did not serve with the military services during the last war and those physicians who had service as medical officers but entered service subsequent to V-J Day.

(d) Those physicians who served the least time in World War II during active hostilities.

The Council also asked that in case of prolonged mobilization some provision be made for the rotation of physicians between the military services and the civilian population.

Red Cross to Handle All Blood for Armed Forces

Washington, D. C., Aug. 7.—The Red Cross will become the official agency for the procurement of Blood for the Armed Forces when such blood and its derivatives are needed, Gen. George C. Marshall, president of the American Red Cross, announced.

The acceptance came after a request by Secretary of Defense Louis Johnson that the Red Cross prepare immediately to "increase the output of its national blood program to provide the Armed Services with the blood that may be required."

General Marshall designated Vice Admiral Ross T. McIntire (M.C.) USN, Retired, of the Red Cross National Blood Program, to work with Dr. Richard L. Meiling, director of Medical Services of the Department of Defense, to coordinate and develop the plan.

At present 34 regional blood centers and 46 mobile units operating in the Red Cross blood program collect about 65,000 pints of blood a month for civilian use. One of the national blood centers is now operating at Madison, Wisconsin.

High Psychoneurotic Case Rate Expected in Korea

Washington, D. C., Aug. 5.—Although not much information is available so far in Washington as to the rate and type of battle casualties in Korea, Far Eastern Field Surgeon, Major General Edgar E. Hume, has sent back word that he expects a high rate of psychoneurotic cases because of the nature of the fighting.

An Army spokesman said that medical supplies, equipment and personnel are in the combat area in sufficient quantity to meet responsibilities. On the scene are evacuation hospitals, mobile clearing companies and mobile surgical hospitals all "in adequate supply and operating."

Casualties whose wounds indicate they will not be able to rejoin their units for 120 days are sent back to the United States. Others are hospitalized in Japan or Korea.

The same Army spokesman said that our troops were not leaving many wounded behind, despite the almost constant retreat. Disease rates have probably gone up under combat conditions.

Army, Navy, Air Force Looking for M.D.s; Only Volunteers Get $100 a Month Bonus

Washington, D. C., Aug. 5.—More than a month after the beginning of the war in Korea military medical service was still critically short of physicians.

With some exceptions, medical reserves are being ordered up only if they are members of an organized unit being placed on active duty. But mandatory orders are likely to be issued soon to unorganized reserves on a wider scale.

At present this is the situation:

ARMY: It is ready to start ordering up volunteer reserve medical men for processing inductees. Appeals to 3,000 reserves in the grades of lieutenant and captain brought only 22 active duty volunteers. It also plans to put into uniform part of the 6,000 government-educated physicians who have served no active duty time.

NAVY: Since August 1, it has been dispatching selective mandatory calls to active duty to some of its reserves. It plans to exhaust organized reserve lists before calling men from volunteer reserves. Appeals for voluntary active duty produced 40 responses.

AIR FORCE: Officials state flatly that they need 500 more doctors now, and a great many more within a short time. Appeals for volunteers brought six doctors to active duty since the first of July.

Officials believe that the $100 monthly bonus for doctors who volunteer for duty will help bring in men. The Army legal department has ruled that under the bonus law, physicians will not receive the extra $100 if they wait for mandatory orders.

Late Bulletins on Doctor Status in War

The Army has announced that voluntary enlistments *will not be accepted after a man has received induction orders through Selective Service.* This applies to physicians as well as others. The theory is, for example, that doctors have had ample opportunity before induction orders are issued to volunteer and claim $100 a month bonus.

* * *

The Army is beginning mandatory call-ups of army medical officers from volunteer (unorganized) reserves. However, the Army has announced it will select such reserves *only after consultation with state and local medical societies.*

* * *

Doctors who volunteer for immediate active duty will get $100 a month bonus. *No bonus is given if the doctor waits* until he is called up.

DOCTORS LISTED AS "ESSENTIAL"

Washington, D. C., Aug. 8.—The department of labor has issued a list which includes doctors among those whose services are essential to the civilian economy.

The list was issued as a guide to military services in considering deferment of reserve officers, and was accepted by the department of defense.

It is purely advisory, and the services remain the final judge of what reserve officers to call up. However, it is an official reminder that the civilian practice of medicine should be given adequate consideration.

Deferments would be for not more than six months, and could not be extended beyond another six months.

Need Thousands of M.D.'s, Laity to Learn Burn Care

Chicago, July 28.—Immediate training of large numbers of physicians or the public, or both, to care for atomic bomb burn casualties has been urged by Dr. E. I. Evans, Richmond, Va., member of the National Research Council's committee on atomic casualties.

"If any large American city suffers atomic bomb attack the numbers of burn casualties will tax all preparations authorities are likely to be able to provide, Dr. Evans wrote in the July 29 AMA Journal.

He urged immediate training of doctors, nurses, and first aid workers in burn care to avoid an "inexcusable loss of many lives."

Congress Plans Early Action on Bills to Draft Doctors

Washington, D. C., Aug. 8.—Fast developments in Washington point toward early action on bills designed to draft government-educated and other doctors who have had little or no active duty, according to the Washington Office of the American Medical Association.

Both H.R. 9311 (Rep. John Saylor, Pa.) and H.R. 9294 (Rep. Anthony Cavalcante, Pa.) provide for Selective Service registration of all persons with "needed professional, technical and specialist" skills who are not yet 45 years of age. From this general listing, physicians could be selected in a specified order.

First to be called would be former ASTP and V-12 men who had served no time on active duty. Others would be called in inverse relation to previous active duty.

Saylor's bill also allows a 60-day deferment for doctors not members of the reserve who apply for commissions.

These bills closely parallel recommendations of AMA's Council on National Emergency Medical Service, and there is no reason to believe they will be opposed by the Defense Department.

Saylor has followed up with another bill, which he thinks will be favorably looked upon, aimed specifically at ASTP and V-12 educated physicians and dentists. Men inducted under this bill would be assured the rank of first lieutenant, and would be required to remain in reserves at least six years after going off active duty.

Medics Call Korea "Unhealthy Place"

Washington, D. C., Aug. 5.—Korea is generally considered by Army medical men as an "unhealthy" place—better than some Far Eastern countries but worse than others.

There is generally no control of the water supply, and human waste is used for fertilizer, as in many countries in that area. Water is unsafe for drinking or bathing. Diseases such as malaria, scrub typhus, diarrhea and intestinal disorders are expected.

The Army maintains that it has adequate supplies of chloroquine, chloramphenicol and dramamine and other proper drugs on hand to fight these diseases.

The experience of four years of occupation in Japan has shown that despite these conditions, the troop disease rate was "not significantly higher" than in other occupation areas. This was due to health discipline measures which are of limited effect in combat.

IT TAKES MORE THAN WORDS

Time's policies are written in the layman's language. We want our policyholders to understand every printed word. But it takes more than printed words! It is the intent of the company behind the policy that really counts.

Time claims are not ADJUSTED. Our claims are REVIEWED as a means of giving all possible assistance when a policyholder becomes a claimant.

The printed words of our policies then mean money for the grocery, hospital, doctor, and rent bills. Each claim becomes a human interest story to our Claim Department, and a means of fulfilling our written promises.

The Time Insurance Company

213 W. Wisconsin Ave.

Milwaukee 3, Wis.

Wisconsin Rural Health Conference Program

Friday, September 22, 1950

12:00 Noon: Registration

GENERAL ASSEMBLY

1:00– 1:10 Welcome Address
M. W. Stuessy, M.D., Brodhead
Conference Chairman
Chairman of Committee on Rural Health
State Medical Society of Wisconsin
Moderator:
W. D. Stovall, M.D., Director,
State Laboratory of Hygiene, Madison

1:10– 2:00 **"Where Are We in Rural Health?"**
Frank Peck, Executive Secretary
Farm Foundation, Chicago
C. N. Neupert, M.D.
State Health Officer, Madison

2:00– 2:20 **"Should We Train More Doctors?"**
W. S. Middleton, M.D.
Dean, University of Wisconsin
Medical School, Madison

2:20– 2:30 Intermission

2:30– 2:50 **"Does Your Community Need a Hospital?"**
Vincent Otis, Director,
Wisconsin Hospital Survey and Construction Division,
State Board of Health, Madison

2:50– 3:10 **"Meeting Health Care Costs Through Prepaid Plans"**
Lloyd J. Yaudes, Director, Public Relations
Wisconsin Mutual Insurance Alliance;
Former actuary, Wisconsin Insurance Department, Madison

3:10– 3:30 **"Organizing to Meet Community Health Needs"**
A. A. Filek, M.D., Director,
Division of Local Health Administration
State Board of Health, Madison
Moderator: Procedure in Sections

4:00– 5:30

SECTION MEETINGS

Section I: "Should We Train More Doctors?"
Chairman:
Oswald Anderson, Wisconsin Farm Bureau, Madison
Discussion Leader:
Burton Kreitlow, Assistant Professor, Department of Education and Dement of Agricultural Education, University of Wisconsin, Madison
Guest Advisors:
W. S. Middleton, M.D., Dean, University of Wisconsin Medical School
J. S. Hirschboeck, M.D., Dean, Marquette University School of Medicine, Milwaukee
Francis Schweinler, Editor, Mosinee Times; President, Wisconsin Press Association
John Wyngaard, Madison Bureau, Green Bay Press–Gazette

Section II: "Does Your Community Need a Hospital?"
Chairman:
Milo Swanton, Secretary, Wisconsin Council of Agriculture, Madison
Discussion Leader:
Arthur Wileden, Professor of Rural Sociology, University of Wisconsin
Guest Advisors:
Vincent Otis, Director, Wisconsin Hospital Survey and Construction Program, Madison
Jack Kyle, Executive Secretary, Wisconsin Association of Cooperatives, Madison
Miss Marie Goebel, Superintendent, Memorial Hospital, Fort Atkinson
John A. VanMeter, Editor, New Richmond News, New Richmond

Section III: "Organizing to Meet Community Health Needs."
Chairman:
Mrs. L. A. Leadbetter, Vice-commander, 13th District, Wisconsin Division, American Cancer Society, Rhinelander
Discussion Leader:
Warren Southworth, Associate Professor of Education, University of Wisconsin
Guest Advisors:
A. A. Filek, M.D., Director, Division of Local Health Administration, State Board of Health, Madison
R. M. Parry, D.V.M., President, Barron County Health Council, Almena
Miss Gertrude Clouse, Secretary, Wisconsin Public Health Council, Madison
David Cowgill, M.D., Medical Director, City-County Health Department, Eau Claire

6:15– 7:30 Dinner
Presentation of Wisconsin Country Practitioner Award

7:45– 9:30 **"The Farmer and the Atom"**
Charles Dunham, M.D., Director,
Division of Medicine and Biology
United States Atomic Energy Commission
Washington, D. C.

★

Saturday, September 23, 1950

GENERAL ASSEMBLY

9:00– 9:45 **Summary of Friday Section Meetings**
Moderator:
W. D. Stovall, M.D., Madison
Discussants:
Oswald Anderson, Chairman, Section I.
Milo Swanton, Chairman, Section II.
Mrs. L. A. Leadbetter, Chairman, Section III.

10:00–12:00
Section IV: "Meeting Health Care Costs Through Prepaid Plans"
Chairman:
William Seffern, Wisconsin State Grange, Van Dyne
Discussion Leader:
Bruce Cartter, Associate Professor of Agricultural Extension, University of Wisconsin
Guest Advisors:
Lloyd J. Yaudes, Director, Public Relations, Wisconsin Mutual Insurance Alliance
Jerry Voorhis, Executive Secretary, Cooperative Health Federation of America, Chicago
L. R. Wheeler, Executive Secretary, Wisconsin Blue Cross, Milwaukee
John Joanis, Assistant Secretary, Hardware Mutuals, Stevens Point
Mark R. Byers, Managing Editor, Wausau Record–Herald

12:00–12:15 **Conference Business**
M. W. Stuessy, M.D., Presiding

12:15 Luncheon
"Rediscovering America"
J. O. Christianson, Superintendent, School of Agriculture, and, Director, Agricultural Short Courses, University of Minnesota, St. Paul, Minnesota

RURAL HEALTH CONFERENCE SET FOR SEPTEMBER 22-23

Doctors Urged to Attend; Atomic Medicine Expert on Program

Madison, Aug. 8.—The possibilities of atomic bombings of Milwaukee, Chicago and Minneapolis and their effect on the Wisconsin farmer will highlight the discussions to be held at the 1950 Rural Health Conference at Green Lake on Friday and Saturday, September 22–23.

The conference, to be held at the Northern Baptist Assembly Camp, is sponsored by the State Medical Society with 55 farm, health, civic and governmental organizations as co-sponsors.

Dr. M. W. Stuessy, Brodhead, chairman of the society's committee on rural health, is directing the

M. W. Stuessy

planning of the conference as chairman of the executive committee.

Dr. Charles Dunham, director of the Division of Medicine and Biology of the U. S. Atomic Energy Commission, Washington, D. C., will give the major conference banquet address on the atomic bomb and the problems and possibilities it poses for farm people in the health aspects of civil defense and biological warfare.

Most of the two day meeting will be devoted to serious discussions of the more immediate local problems of the supply of physicians, availability of hospitals, meeting health care costs through voluntary prepaid plans, and organizing county health councils and city-county health departments.

The conference begins at 1 p.m. Friday, Sept. 22 and closes after lunch on Saturday, Sept. 23.

With Dr. W. D. Stovall, Madison, acting as moderator, the conference will open with a discussion of "Where are We in Rural Health?" by Frank Peck, executive secretary of the Farm Foundation, Chicago, and Dr. C. N. Neupert, State Health Officer, Madison.

The next hour-and-a-half will be given to "survey" talks by Dr. W. S. Middleton, dean of the University of Wisconsin medical school; Vincent Otis, director of the hospital survey and construction division of the state board of health; Lloyd J. Yaudes, director of public relations, Wisconsin Mutual Insurance Alliance, Madison; and Dr. A. A. Filek, director of the division of local health administration of the state board of health.

The remainder of the afternoon will be devoted to three discussion groups, running concurrently, on the topics "Should We Train More Doctors?", "Does Your Community Need a Hospital?", and "Organizing to Meet Community Health Needs."

An outstanding general practitioner will receive the "Wisconsin Country Practitioner Award" created for this meeting by the Executive Committee of the conference.

J. O. Christianson, superintendent of the school of agriculture of the University of Minnesota, will close the conference with an address on "Rediscovering America."

1950 Rural Health Conference Executive Committee

M. W. Stuessy, M.D., Brodhead, Chairman

Walter H. Uphoff, Oregon, Wisconsin Association of Cooperatives

W. C. Voskuil, Racine, Wisconsin Agriculturist and Farmer

A. A. Filek, M.D., Madison, Wisconsin State Board of Health

Miss Edith Bangham, Madison, Home Economics Extension, University of Wisconsin

O. H. Plenzke, Madison, Wisconsin Education Association

W. C. Tormey, D.D.S., Madison, Wisconsin State Dental Society

Miss Grace T. Crafts, Madison, Wisconsin Hospital Association

W. D. Stovall, M.D., Madison, Wisconsin Association for Public Health

Alba J. Groves, Viroqua, Catholic Rural Life Conference

Print New Pamphlets for Patients' Use

Madison, Aug. 10.—Two outstanding pamphlets—one on coronary heart disease, the other on chicken pox, mumps and German measles—have been published for public consumption by the Wisconsin State Board of Health.

Physicians are invited to order these well written, colorful and visually-attractive pamphlets in any quantity from the state board.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions
References furnished on request.

Dr. Zellmer Honored by 32nd Division

Antigo, Aug. 1.—Dr. C. E. Zellmer, Antigo, was honored by national guardsmen of the 32nd Division at its first "Employers' Day" held at the suggestion of Major General Jim Dan Hill, Superior, division commander, who suggested that employers visit the camp to see how their workers are doing in uniform.

Each community with a unit in camp was permitted to select two visitors for this special day.

The Antigo Journal for July 27 stated:

"In naming Dr. Zellmer, the Antigo unit was paying him honor. The men of the unit felt that they owed him a great deal for his efforts on their behalf and chose this means of repaying him.

"Dr. Zellmer was instrumental in the organization of a national guard unit here and serves as the company's unofficial physician. He administered all of their required immunization shots and has given many extra physical examinations without charge."

DIRECT A.M.A. AD CAMPAIGN

Clem Whitaker

Leone Baxter

(See message on next page)

College Staff Doctors Urged to Return Surveys

Chicago, July 31.—Physicians serving as directors and staff members of college health services are urged to cooperate in the second AMA survey of University and College Health Services by returning their questionnaires as soon as possible. Only 150 of the 1,150 questionnaires have been returned.

Eight Hospital Projects OK'd for Rural Areas

Madison, Aug. 1.—Eight new hospital projects in rural areas have been approved by the state board of health, according to Vincent F. Otis, director of the division of hospital survey and construction.

Their cost is estimated at $2,904,000 of which the federal government will contribute $1,279,000.

Three new hospitals will be constructed: Hayward, 15 beds; Hillsboro, 27 beds; and Waupaca, 40–50 beds.

Five additions are scheduled: Viroqua, 20 beds; Rhinelander, 43 beds; New London, 16 beds; Merrill, 28 beds; and Richland Center, 20 beds.

To date 43 projects have been approved calling for 1,297 general hospital beds, 728 beds in other categories, and a new state laboratory of hygiene building.

Total cost for all facilities exceeds $34,000,000, with the federal government's share at nearly $8,400,000.

DOCTOR HAS DUTY TO ADVISE PATIENT WHO DRIVES WITH BAD EYES

Madison, Aug. 10.—The motor vehicle department apparently sympathizes with the patient who drives home bleary-eyed or "half blind" after an ophthalmologic treatment from his physician.

In response to an inquiry from the State Medical Society, B. L. Marcus, commissioner of the department, indicated that the regulations "wink" at driving by persons with temporary eye defects, but place a definite responsibility upon the physician for advising the patient and the department under certain conditions.

Should Report Cataracts

For example, one-eyed persons are licensed to drive provided they have at least 20/40 vision acuity in the remaining eye. There are no regulations regarding a temporary situation in which a person has to drive with one eye completely covered.

Persons with a cataract in one eye are required to have periodic examinations to assure that vision in the remaining eye is not reduced and remains better than 20/40 in visual acuity.

Physicians are requested to notify the motor vehicle department of patients having cataracts and to tell such patients that the department requires periodic reexamination of the unaffected eye.

Commissioner Marcus declared that the doctor has fulfilled his obligations when he advises his patient not to drive if he believes the patient's vision is such that it will affect his ability to operate a vehicle safely.

U.W. CANCER GRANT

Madison, Aug. 10.—The University of Wisconsin received $3,866 out of a total of $1,160,818 in public health service grants to intensify the nationwide attack on cancer.

Wisconsin's share will be used under the direction of Dr. Harold P. Rusch of McArdle Institute for physiological and biochemical studies of mice in relation to their resistance to tumor formation.

VFW Fails to Oppose Socialized Medicine

Oshkosh, June 24.—The state convention of the Veterans of Foreign Wars did not take a definite stand in opposition to socialized medicine at its 1950 encampment.

Delegates sent back to committee a resolution "against any form of compulsory health insurance or any system of political medicine designed for national bureaucratic control."

AMA TELLS NEWSPAPERS OF AD CAMPAIGN

Gentlemen:

Your newspaper will receive an insertion order early in September from Lockwood-Shackelford Company, 57 East Jackson Blvd., Chicago, the agency selected to handle this business, for a 70-inch (5 columns x 14 inches) display advertisement of the American Medical Association.

The copy is scheduled to run during the week of October 8th.

This advertising campaign, sponsored by the doctors of your community, and throughout the Nation, opens the door to *a "tie-in" advertising program of impressive proportions*—and this letter, in part, is to advise you of the opportunity for a successful promotional campaign locally.

The advertising budget approved by the A.M.A. Board of Trustees totals $1,110,000, with $560,000 allocated to newspapers, $300,000 to radio and $250,000 to National magazines.

Approximately 144,500 individual doctors, in every community in America, will share the cost of this advertising program through their dues payments to A.M.A. One of the major purposes of the ad copy will be to increase the availability of medical care to all the American people through extended use of the medium of Voluntary Health Insurance.

We believe you will want to know *"the story behind the ad"*, not only because it will aid you in your "tie-in" campaign, but because the doctors' program has real significance to you and all your readers.

This, without doubt, is the broadest-coverage newspaper advertisement of the year, judged from the standpoint of the number of newspapers included in the schedule.

The A.M.A.'s schedule will run in approximately 11,000 newspapers, including every bona fide daily and weekly paper in the 48 States, the District of Columbia and the territories of Hawaii and Alaska. (We will not be able to include free-distribution papers, lodge or other special group publications, or the foreign language press, in this schedule.)

There's a sound reason for this blanket-coverage policy.

This is a "grass roots" advertising campaign, directed to all the people of America, whether they live in great cities, small towns or villages. Wherever there is a newspaper, there are doctors—and doctors' patients. And the A.M.A. advertising program is designed to blanket every area of medical practice.

Consequently, the A.M.A. schedule calls for the use of advertising space in all the newspapers of America. There will be some duplication of circulation, but the added impact of that duplication is desired, so that medicine's story can be hammered home by repetition.

To aid in building advertising impact, more than 300 radio stations and approximately 30 of the leading National magazines, in addition to a score of advertising trade publications, will carry medicine's message. The radio and magazine campaigns also are scheduled for October.

In evaluating the "tie-in" possibilities of this schedule, you will want to know what the A.M.A. copy is designed to sell.

The commodity which the A.M.A. copy will advertise is an already widely-accepted, thoroughly-recognized, American product—Voluntary Health Insurance. The A.M.A. ad copy will not seek to sell any particular brand or plan of Voluntary Health Insurance, but the individual will be encouraged to secure sound coverage in the plan which he feels best suits his individual needs.

There are several hundred prepaid medical-hospital systems and accident and health insurance companies in the United States, all competing for business in this field, in addition to the various labor, industrial and fraternal plans—and every sound system of Voluntary Health Insurance should benefit from the A.M.A. advertising program.

American medicine's objective, however, is solely to increase the availability of good medical care—and the advertising copy will be designed to make the American people "health insurance conscious", so that prepaid health protection will gain general acceptance as a means to cushion the economic shock of illness.

The possibilities for "tie-in" advertising copy, as you can readily understand, are tremendous. There are insurance men and representatives of prepaid medical-hospital systems in every section of the country who would benefit by buying "tie-in" space at the time the A.M.A. copy is scheduled.

That is only part of "the story behind the ad", however.

The principle which the A.M.A. copy will seek to strengthen and bulwark is the basic American ideal of individual freedom, individual initiative and freedom of opportunity—under a free economy, as opposed to the alien philosophy of a Government-regimented economy. In this aspect, the copy will be used to alert the American people to the danger of socialized medicine—and to sharpen public awareness of the threatening trend toward State Socialism in this country.

Here, again, there are many opportunities for "tie-in" copy in every community.

Socialized medicine is a direct threat to the hospitals and druggists in your community, to the dental profession as well as the medical profession—and to every insurance company which handles health and accident coverage.

The scope of this program, however, is broader than that.

State Socialism has become a real threat to every form of private endeavor—and the A.M.A. copy will sound that keynote.

When you receive a mat of the A.M.A. advertisement early in September, you also will receive material for the use of your Advertising Sales Department in selling "tie-in" advertising.

Copy and mats for approximately 20 suggested "tie-in" ads will be sent you without cost; the copy in some of these ads will be slanted to interest specific businesses or groups in your community, while other suggested "tie-in" ads will be suitable for use by any advertiser willing to participate in a "Freedom Roll Call".

We believe that as a citizen, as well as in your newspaper capacity, you will find yourself in warm accord with American medicine's program—and we will be grateful for your assistance in making this Nationwide advertising program successful.

(Signed) CLEM WHITAKER
LEONE BAXTER
Campaign Directors

Most Wisconsin Congressmen Aid in Defeat of Plan No. 27

Washington, D. C., July 13.—After a full dress, two-hour debate the House of Representatives defeated President Truman's Reorganization Plan 27 which would have elevated the Federal Security Agency to cabinet rank as a Department of Health, Education and Security.

Seven of Wisconsin's 10 representatives voted against Plan 27, one voted for it, and two were paired. The plan was defeated 249–71.

Administration spokesmen concentrated their attack on the AMA. Critics of Plan 27 emphasized the sound government issue, arguing that Plan 27 promised neither economy, efficiency nor better medical care.

Democratic leaders got their main help from Representatives Andrew Biemiller, Wisconsin, and Chet Holifield, California. However, 106 Democrats joined 143 Republicans to doom the proposal.

How Wisconsin Congressmen Voted on Plan No. 27

Voting Against Plan No. 27

Smith, 1st District
Davis, 2nd District
Withrow, 3rd District
Murray, 7th District
Byrnes, 8th District
Hull, 9th District
O'Konski, 10th District

Voting for Plan No. 27

Biemiller, 5th District

Paired*

Zablocki, 4th District
Keefe, 6th District

*** Paired votes are not counted in the total vote. It is done only to permit an absent member to record his vote—in this instance, Zablocki in favor of Plan 27, Keefe against.**

The outcome of the vote was influenced by a belief, strongly expressed in debate, that the case for compulsory health insurance would be advanced if the Federal Security Agency received a voice in the government at cabinet level.

John W. Byrnes, Green Bay, representative from the 8th Wisconsin district, wrote State Medical Society President John W. Truitt following the vote:

"You may rest assured of my continued opposition to any proposals which I believe would destroy the high standards of medical practice achieved in this country by a free and independent medical profession."

Alvin E. O'Konski, Merrill, congressman from the 10th district, Wisconsin, wrote:

"I will always oppose legislation that is inimical to the health of the people."

Rep. Glenn Davis, Waukesha, 2nd district, declared:

"I will continue to fight as vigorously as I have in the past against proposals presented as reforms for the benefit of the people, but which are actually part of a master plan to concentrate vast power in the hands of a tightly-knit group of Washington planners."

Said Congressman Lawrence H. Smith, Racine, 1st district:

"I am not in favor of compulsory health insurance, and very frankly, this bill would have been a step in that direction."

Legion Says Only 19% of VA Cases Are Non-Service

Washington, D. C., August 25.—The American Legion has reached the conclusion that only 19 per cent of VA's hospital cases are strictly non-service connected.

It reached this decision after analyzing a report prepared for it by the VA. The American Legion reports that 81 per cent of all VA hospital patients fall into the following classes:

1. Established service connected illnesses or injuries.
2. Have at one time or another applied for pension or service connected certification.
3. Are not eligible to apply for such certification for various reasons, principally because they are mental cases.

This analysis is in conflict with other studies of the VA hospital situation which placed the percentage of non-service connected cases at 50 to 70 per cent. The Legion also notes that many veterans, particularly mental and tuberculosis cases, are appealing from adverse rulings, and for this reason should not be listed as non-service connected cases.

HOUSE COMMITTEE REVEALS EWING'S LOBBY EFFORTS

Washington, D. C., July 28—A House investigating committee has brought out the details of government lobbying at the taxpayers' expense on behalf of President Truman's socialized medicine program.

Federal Security Administrator Oscar R. Ewing was a reluctant witness as Rep. Halleck of Indiana and Rep. Brown of Ohio pried testimony from him concerning the manner in which pressure has been put upon Congress by his agency for a passage of compulsory health legislation.

Ewing denied a suggestion that he might have violated the criminal statute which forbids use of federal funds to bring influence to bear upon the passage or defeat of legislation.

The committee scrutinized Ewing's six-weeks trip to Europe (an official mission, not a junket, Ewing emphasized); 33 speeches throughout the nation and the services of 65 full-time government press agents.

Ewing said he had made 33 speeches this year in various parts of the United States, at government expense. He said he couldn't calculate the cost to the taxpayers of these expeditions. He admitted his agency had 65 full-time publicity men helping prepare the speeches.

Ewing was quizzed at length about the formation of National Health Assembly, Inc., a private corporation, in which agency employees and his brother-in-law acted as officers. Based on the assembly's work he issued a "report to the President" advocating socialized medicine, 59,000 copies of which were printed at a cost to the government of about $20,000.

AMA Opposes United Medical Agency Bill

Washington, D. C., July 31.—Dr. Walter B. Martin, Norfolk, Va., appeared at a recent senate hearing to oppose S. 2008, a bill to consolidate certain hospital, medical and public health functions in a United Medical Administration.

The bill was also opposed by the American Legion, Veterans of Foreign Wars, Amvets and other agencies and organizations.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Industrial Hygiene Engineering Services to Industry

American industry is characterized by constant progress. The progressive changes and technological advances result directly from active programs of research and production studies. The progress in industrial health and safety has proved beneficial not only to the employee but to industry.

One of the important production problems with which medical, personnel, and safety departments are concerned is the provision of healthful working conditions. In many industrial processes, toxic chemicals used as raw materials or formed in the process are unavoidably dispersed as waste into the plant atmosphere and the breathing zone of the workers. This airborne waste material exists in one of four physical forms: dust, fume, gas, or vapor. Exposure for a prolonged period of time to excessive atmospheric concentrations of any physical form of a toxic chemical usually results in occupational disease.

What practical role does the Industrial Hygiene Division of the State Board of Health play in modern industry? As the name implies, industrial hygiene is concerned with the promotion and maintenance of the health of industrial workers. The industrial hygiene engineers of the division work with industry in the control of occupational disease. A major phase of their work consists of the measurement of the concentration in the plant air of any physical form of toxic materials. In determining the concentration, numerous air samples are collected throughout an eight hour working day. The results of the chemical analyses of all of these air samples are taken into account in arriving at the average concentration to which the plant workers are exposed. The average concentration determined in the plant study is then compared with a nationally accepted standard of maximum allowable concentration for the particular toxic chemical. The maximum allowable concentration is defined as that concentration which may be tolerated by a normal individual for an eight hour working day, day after day, without producing any harmful bodily effect. In this manner, the industrial hygiene engineer, through a systematic quantitative approach, correlates the concentration of the causative agent present in the plant atmosphere with a nationally accepted tolerance limit. Studies such as this enable the industrial hygiene engineers to define the needs for environmental control in meaningful terms. Similarly, these quantitative studies may serve as the basis for effective medical control.

Sometimes the evaluation of the exposure of employees to a toxic air contaminant is more readily and more accurately done through clinical methods. A case in point is that of an industrial plant which recently requested the services of the Industrial Hygiene Division of the State Board of Health in evaluating the exposure of a group of welders who were about to start work with a leaded steel alloy. At the temperature of an electric welding arc, lead is volatilized from the alloy and is dispersed into the air at the breathing zone of the welders as a lead fume. With point sources of highly concentrated toxic fume, it is quite difficult to evaluate the welder's exposure through an engineering study based upon air sampling. This difficulty is apparent when one considers that air samples collected in an engineering study must be representative of the air breathed by the employees involved in the study. To assure an accurate evaluation of the lead exposure, a planned program of clinical controls was instituted.

It is known that continued daily inhalation of lead fumes in excess of the maximum allowable concentration of 0.15 mg. of lead per cubic meter of air will result in a significant excretion of lead in the urine. Urinary lead concentrations over 0.15 mg. of lead per liter of urine are considered indicative of excessive lead absorption. Continued inhalation of an excessive concentration of lead will in time also produce a decrease in hemoglobin content of the blood and an increase in the stippled cell count.

In view of the characteristic changes in these body fluids resulting from continuous execessive intake of lead, it is possible through urinary lead analysis, oxyhemoglobin determination and stippled cell count to evaluate lead exposure. In a clinical study of this nature, the individual serves as the air sampling device and the concentration of the toxic air contaminant is indirectly determined by the extent of the changes occurring in the composition of the two body fluids, blood and urine. Arrangements were made with the personnel and medical departments of the plant to collect urine and blood samples from each of the welders before they started to work with the leaded steel alloy. These samples were analyzed to determine the normal urinary lead content of each of the welders as well as the oxyhemoglobin and stippled cell count. Similar samples will be collected quarterly and the results of the analyses will be compared with the nor-

(Continued on page 730)

Wisconsin Anesthesia Study Commission

Of the Wisconsin Society of Anesthesiologists

EDITOR—LUCIEN E. MORRIS, M. D., Madison*

A number of finely balanced physiologic mechanisms can be disturbed during even the most expertly administered anesthetic. It is important to keep to a minimum such deviations from normal. Since it is unlikely that any single individual's experience may adequately encompass all types of difficulties and mishaps, a system for sharing such experiences has been adopted by the Wisconsin Society of Anesthesiologists. Comments upon and evaluation of selected cases are intended to direct attention to considerations sometimes overlooked, awareness of which may possibly decrease the incidence of similar difficulties in other hands, and indirectly increase the safety of Wisconsin patients. Anonymity of contributors will be maintained. Your participation is invited.

Several descriptions have been received of convulsions during anesthesia. Reports of two typical cases follow.

CASE 11.—On the first hot, humid day of summer a healthy 2 year old boy was to have his cleft palate repaired. Previous anesthesia history was satisfactory.

Premedication was 0.3 mg. of atropine. Induction was with ethyl chloride followed by open drop ether. Nasotracheal intubation with a No. 2 Magill tube was done with the aid of a laryngoscope, and anesthesia maintained with ether-oxygen, using an Ayre T tube without an extension on the side arm, and a 2 liter flow of oxygen. The operative course was uneventful. What was thought to be light surgical anesthesia was maintained for one and one-half hours.

The anesthetic was discontinued five minutes before the completion of the operation. Just as the operation ended the patient moved, as if coughing on the endotracheal tube. The tube was quickly removed. When the drapes were removed the patient was opening and closing his eyes, as if consciousness were returning. However, there were fine twitching movements of the muscles around the eyes and mouth, and the child was pale and rather cyanotic. The color improved when a gravity flow of oxygen was added to the inspired air.

For the next 15 minutes the respirations were jerky, and the color was good only when oxygen was administered; the twitching of the face muscles continued and there were occasional generalized clonic convulsions, each lasting a few seconds. The pupils were large, and the corneal reflex was absent. Gradually the respirations became smoother, the color was good, so administration of oxygen was discontinued when the twitching movements ceased. Reflexes returned slowly and the child was conscious 35 minutes after the end of anesthesia. The postoperative course was uneventful.

CASE 23.—A 2 year old girl was to have a cleft palate repaired. After premedication with 0.1 mg. of atropine, a pre-induction rectal temperature was 99 F. Anesthesia was induced with high flow of nitrous oxide and oxygen and continued with ether. Maintenance during the operation was accomplished by insufflation of ether and oxygen through a soft pharyngeal catheter. The patient was heavily draped and the operating room was unusually warm and poorly ventilated.

Convulsions occurred after 58 minutes of anesthesia. The operation was stopped, and artificial ventilation was provided with oxygen. Convulsions ceased but they recurred repeatedly at brief intervals. Rectal temperature at this time was 102.6 F. A small amount of pentothal was administered rectally, and ventilation with oxygen was continued. The operation was then completed in about ten minutes and the patient returned to her room. Her recovery was satisfactory and no further convulsions occurred.

Comment

Many factors which in some way alter the environment of the individual have been suggested as single causes of convulsions during anesthesia. Evidence indicates, however, that probably a summation of several factors is necessary to provide the increased irritability of the central nervous system which is required to induce convulsions in an anesthetized individual.[1] The most frequently mentioned predisposing factors are youth, infection, and fever.[2] The initiating factors seem usually to be associated with the management of the anesthetic period and are concerned, first of all, with disturbances of heat regulation, which lead to hyperpyrexia; and, secondly, with changes in the acid-base balance, which increase tissue acidity.

Attention to effective preventive measures will make the occurrence of convulsions during anesthesia a rare complication. Needlessly overheated operating rooms, heavy operating room drapes, dehydration, the excessive drying action of atropine, and anesthetic systems which retain either heat or carbon dioxide should be scrupulously avoided. Judicious use of ice bags may be of value in keeping the temperature of a patient controlled. The adequacy of ventilation must be vigilantly maintained. Depressed or obstructed respiration cannot be tolerated, because either quickly leads to an insufficiency of oxygen and an increase in carbon dioxide with consequent acid-base imbalance.

After convulsions have begun during an operation, all possible etiologic factors must be removed. Obviously the surgical procedure and the adminis-

(Continued on page 730)

* Present Address—Division of Anesthesiology, Department of Surgery, State University of Iowa College of Medicine, Iowa City, Iowa.

. . . . THE PRESIDENT'S PAGE . . . .

The Doctors Go to the People

A YEAR ago almost any average American citizen would have said, "Maybe you doctors *are* right, but why don't you tell your story?" Then came the American Medical Association's National Education Campaign, with its pamphlets, posters, endorsements, speeches, newspaper and radio stories, and magazine articles. The resolutions testifying the support of more than 10,000 organizations in the fight for medical freedom are certain proof that millions of Americans now understand the issues at stake.

Now the president of the American Medical Association has revealed the next logical step in this program to explain where the medical profession stands, what it has to offer, why it is against socialized medicine, and what the doctors have done and can do without government domination. A national advertising campaign costing $1,110,000 will be launched in October.

Every bona fide daily and weekly newspaper, nearly 11,000, will carry approximately 70 inches of copy during the week of October 8. Hundreds of radio stations, covering every state, Hawaii, and Alaska, will offer "spot announcements." The leading national magazines and many advertising trade publications will be included.

Medicine's well organized plans to sell the American citizen on voluntary health insurance and opposition to the alien philosophy of a government-regimented economy now include advertising—the time-tested method of selling—in media of proved effectiveness for reaching the public. These advertisements will be visible, audible proof that the national association is doing effectively the job it has declared it will do in informing the American people. The ad copy will be designed to make the American people "health insurance conscious" and to encourage the extension and development of voluntary prepaid medical and hospital care as a means of taking the economic shock out of illness. It will sell voluntary health insurance, not any particular brand or plan—but any sound coverage best suiting the individual's needs. At the same time, the ads will be used to crystallize general public sentiment into concrete public expression in support of the principle of individual freedom.

In his inaugural radio address, the new president of the American Medical Association, Dr. Ernest L. Henderson, said that American newspapers with few exceptions, have taken a strong stand, not only against socialized medicine, but against all forms of state socialism, and that the doctors are proud to join the "fighting editors in the battle to save our freedom."

Said the editor of a Wisconsin weekly: "This position of the American press is not surprising. Newspaper people have an exceptionally good understanding of what socialism has done to the economics and liberties of other peoples—and they are completely aware of what it could do here."

This crucial phase of the National Education Campaign merits the hearty endorsement of every physician; and doctors and medical societies throughout Wisconsin should lend their willing support to the plan by encouraging "tie-in" advertising through newspapers and radio stations from physicians, hospitals, health insurance agencies, pharmacists, and a broad cross-section of business and industrial concerns. This is an opportunity for medicine to tell the story behind the ad—a story that has real significance for every doctor and every layman.

John Wm Truitt MD

The State of Wisconsin
STATE HISTORICAL SOCIETY
816 State Street
Madison 6, Wisconsin

CLIFFORD L. LORD
DIRECTOR

TO THE MEMBERS OF THE WISCONSIN MEDICAL SOCIETY

Who are the leaders of Wisconsin Medicine who should be included in a state biographical dictionary? This Society addresses this question to you as being the most interested of all. The projected Dictionary of Wisconsin Biography should represent the best in thought, skill, and leadership, and a distinguished Board of Editors is being assembled to judge the selection. But the professions are in the best possible position to judge their own leadership.

We are therefore requesting you to cooperate with the officers of the Wisconsin Medical Society in bringing the distinguished figures of Wisconsin medicine to the attention of the sponsors of the Dictionary. Your nominations and comments will be carefully studied, and suggestions as to possible contributors of sketches will be welcomed. Please address them to the Editor of the Wisconsin Medical Journal.

The only limitation which must be observed is that the proposed subject be deceased. Living persons may not be included in the Dictionary. This is a standard provision in all such projects.

Proposed subjects should be people who in your estimation have contributed to medical knowledge, practice, teaching, and organization. Please let us have the benefit of your judgment.

Sincerely yours,

Wilbur H. Glover

Wilbur H. Glover
Acting Director

WHG/g

Minutes of the Council Meeting, Madison, June 3-4, 1950

1. Call to Order

The Council was called to order by Chairman Arveson at 2:00 p.m., Saturday, June 3, 1950, at the Society's office, Madison.

2. Roll Call

Councilors present were Doctors Eck, Hemmingsen, Tenney, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Christofferson, Arveson, Ekblad, Galasinski, Pierce, Wegmann, Chairman Emeritus Gavin, and Past-President Doege.

Also present were President Truitt; Speaker of the House of Delegates Stewart; Treasurer Sisk; Dr. Gunnar Gundersen, member of the Board of Trustees of the American Medical Association; Delegate to the A.M.A. Stovall; Dr. J. S. Supernaw, chairman of the Veterans Medical Service Agency; Dr. R. E. Fitzgerald, chairman of Committee on Grievances; Dr. C. N. Neupert, state health officer; Dr. R. C. Parkin, director of "March of Medicine" radio program; Dr. James Sullivan, Milwaukee; Drs. N. A. Hill, P. B. Mason, Milton Finn, and Roger Garrison, members of the Directing Board of Wisconsin Physicians Service; Dr. Richard Foregger, Milwaukee; and Dr. Paul E. Campbell, Waukesha; Secretary Crownhart; Assistant Secretary Ragatz; Mr. T. J. Doran, director of Veterans Agency; Mr. R. F. Weber, director of Wisconsin Physicians Service; Mr. Earl Thayer, director of Public Information; Mr. Robert Murphy, legal counsel; Mr. Donald Gill, certified public accountant; Miss Helen L. Brandt and Mrs. Shirley Thompson of the Society's office.

3. Wisconsin Physicians Service Report and Recommendations

Dr. E. M. Dessloch, chairman of the Directing Board of Wisconsin Physicians Service, presented a report and recommendations of the Directing Board. A summary of operations from December 1, 1946, to March 31, 1950 revealed $2,435,439.35 in earned premium income; $1,769,977.90 in claims paid to physicians; administrative expenditures of $392,195.04, leaving $273,266.41 available for reserves. Cash, including cash in hands of agent as of March 31, 1950, was $408,676.22; $151,800 in U. S. government bonds; fixed and other assets, $4,024.92; less liabilities $271,234.73; and the advance made by the State Medical Society $20,000.

Recommended changes were considered, and the following actions taken: On motion of Doctors Ekblad–Wegmann, carried, the Council authorized the Directing Board of WPS to offer a basic surgical and maternity group contract, without anesthesia, x-ray or medical benefits.

On motion of Doctors Bell–Galasinski, carried, the Council authorized the Directing Board, upon completion of its studies, to submit for approval such riders as, in its judgment, should be offered in connection with the new basic group contract.

On motion of Doctors Pierce–Ekblad, amended by Doctor McCarey, the following resolution was passed: The Directing Board of Wisconsin Physicians Service was authorized to develop and sell a cost-plus service contract, utilizing the features of group contracts now authorized, such contract to be offered to groups only in special and carefully controlled situations, periodic reports of all such contracts to be made to the Council, such authority to be subject to the following conditions:

a. All cost-plus contracts shall be subject to the proration of benefits should such proration be necessary among the other contracts written by Wisconsin Physicians Service.
b. No cost-plus contract may be written on a guaranteed maximum premium basis.

On motion of Doctors McCarey–Pierce, carried, the Council authorized the Directing Board of WPS in its discretion, and not as a routine matter, to write group contracts for periods up to one year.

On motion of Doctors Eck–Christofferson, carried, the Council approved changing the name of this program from Wisconsin Physicians Service to the Blue Shield Agency of the State Medical Society of Wisconsin.

3. Secretary's Report

The secretary presented a report on prepaid health plans in Wisconsin which was considered in executive session, in connection with various problems in the conduct of the Society's prepaid programs.

By action taken in executive session the Council:

a. Referred the secretary's report to the Coordinating Committee on Prepaid Health Plans for study.
b. Authorized the employment of a consulting actuary and appropriated $7,500 for that purpose.

It was the recommendation of the Interim Committee to the Council of the State Medical Society, and adopted by the Council, that, in the interest of harmony, efficiency, and good business procedure, the Secretary of the said Society be, in effect, the General Manager of the Society; further,

1. That he is to be the liaison officer between the Council and the various committees of the Society and, further, that he is to keep the Council informed at all times of any important decisions of these committees. Further, that the Council will hold him strictly to account in these matters.

2. That all employees of the State Medical Society will be under his supervision and that they will take orders from him upon such matters and routines as he may direct.

That he shall employ all such subordinates and discharge them for any neglect of duty as he deems necessary for the smooth and perfect operation of the Society's office.

3. It is the order of the Council by a unanimous vote taken at the June meeting to move the office of Blue Shield from Milwaukee to Madison and that it be housed in the State Medical Society's building at earliest practical date.

4. That all employees be paid by check by the State Society.

5. The Council intends to follow the House of Delegates' instructions that it operate the two insurance systems in the name of the State Society and under no circumstances will it allow, unless so directed by the House of Delegates, the formation of a separate and independent system of voluntary insurance involving these plans.

4. Approval of Minutes

On motion of Doctors Christofferson–Eck, carried, minutes of the February 18–19 meeting of the Council as published in the May, *Wisconsin Medical Journal*, were approved.

At this point, the Council recessed until 9:30 Sunday morning.

5. Spinal Barbitage

Dr. R. C. Parkin, medical director of the two Society approved plans, presented a report with regard to the procedure involved in spinal barbitage. It was noted that the procedure had been investigated inasmuch as claims are now being filed for settlement under the prepaid plans.

On motion of Doctors Galasinski–Christofferson, carried, the Council disapproved payment of benefits for spinal barbitage under the prepaid plans.

6. Double Coverage

The Coordinating Committee on Prepaid Health Plans had considered the question of whether full coverage should apply under the Society's prepaid plans when a patient has coverage under one of the plans and also receives payment from another insurance policy. The Coordinating Committee recommended that in this instance full coverage not apply, and the physician not be committed to the fee schedule for the prepaid plans.

On motion of Doctors Bell–Galasinski, carried, the Council determined that full coverage not apply in the case of double coverage, and that the policies be ridered if necessary to make this provision effective.

7. Statement of Income

The House of Delegates in October, 1949, passed the following resolution presented by the Dane County Medical Society:

"*Resolved* that the Council of the State Medical Society be asked to direct studies by the prepaid plans to ascertain feasible means by which the plans shall require, as a part of the claim procedure, a statement by the covered person containing representation as to his income and consequent eligibility under the plans."

On motion of Doctors McCarey–Galasinski, carried, the Council approved a proposed statement of income form for a trial period.

8. Report of Wisconsin Veterans Medical Service Agency

Dr. J. S. Supernaw, chairman, made the following report with regard to the Veterans Agency:

The contract for the fiscal year 1951 with the Veterans Administration has been signed and returned to Washington. Total authorizations from the Veterans Administration up to June 1, 1950, were $1,278,834, total claims filed with the V.A. $1,017,129, total cash disbursed to physicians $902,123. Total authorizations received in the eleven month period just preceding amounted to $220,000.

Appropriations of the V.A. have been cut, and representatives had informed the Veterans Agency committee that they were able to authorize only the bare necessities for out-patient treatment.

In event the present contract with the V.A. is cancelled and the V.A. requests that only a liaison committee be appointed to work with that group, the Council's advice was sought.

On motion of Doctors Dessloch–Kasten, carried, the Council determined that in event the Veterans Administration cancels the contract with the Society, connections with the V.A. be severed completely.

9. Public Meeting at Annual Meeting Approved

The Interim Committee recommended that a public meeting be provided at the time of the Annual Meeting. Mr. Cecil Palmer of England would be available to address such a meeting, as well as the Annual Dinner. An appropriation of $750 would be required from the general funds of the Society.

On motion of Doctors Christofferson–Dessloch, carried, this recommendation was approved.

10. Special Luncheon and Exhibit on Administrative Procedures Approved

The suggestion was made that at the 1950 Annual Meeting a special exhibit and luncheon devoted to business procedures and problems in medical practice be provided. The Clinic Managers Association is willing to cooperate in arrangements for them. The Council on Scientific Work referred the suggestion to the Council, and the Interim Committee recommended that it receive favorable action.

On motion of Doctors Dessloch–Hemmingsen, carried, the recommendation was approved.

11. Report of Committee on Grievances

Dr. R. E. Fitzgerald, chairman, presented a report on the activities of the Committee on Grievances, in which he stated that a letter was sent to members of the Supreme Court and circuit judges, indicating the willingness of the committee to re-

view medical expert testimony that might be questioned, either by judges, administrative officers, or attorneys involved. A similar letter was sent to the Industrial Commission with the addition that should the Commission have any question on the fairness or propriety of physicians' charges, the committee would investigate.

The committee further referred to the Council for its consideration a letter to judges of all courts of record, directors of county welfare departments, and district attorneys, with regard to the availability of the committee. On motion of Doctors Dessloch–Kasten, carried, the letter was approved.

12. Notices on Prescriptions

The Wisconsin Pharmaceutical Association feels that public interest requires more emphasis on the necessity of prescriptions for certain drugs. The Association had prepared several notices for use by drug stores, and wished to have them circulated to these institutions over the joint signature of the Society and the Association. The Interim Committee suggested that the Council authorize circulation of them over the letterhead of the Pharmaceutical Association which can state the approval of the Society to the project.

On motion of Doctors Fox–Dessloch, carried, this suggestion was approved.

13. Clinic-Owned Pharmacies

The Wisconsin Pharmaceutical Association believes that clinic-owned pharmacies are contrary to the principles of medical ethics, and asked the cooperation of the Society in eliminating such pharmacies in Wisconsin.

On motion of Doctors McCarey–Kasten, carried, this matter was referred to the Committee on Grievances.

Doctor Fitzgerald, chairman of the Committee on Grievances, also asked for authority of the Council to send a notation to each member of the profession with regard to dispensing. On motion of Doctors Bell–Kasten, carried, this authority was granted.

14. Clinic for Multiple Sclerosis

Dr. Hans Reese and Dr. E. P. Roemer were present to outline for the Council a proposed clinic for the care and treatment of multiple sclerosis on a statewide basis. Doctor Roemer stated that the cooperation of the physicians in the state was necessary to assist in this program. While physicians would treat their own patients, treatment recommended by the clinic would be followed and the results of that treatment would be compiled so that complete data are maintained.

Doctor Reese, a director of the National Multiple Sclerosis Society, explained that various research centers have been created throughout the country. It is hoped that a Wisconsin Chapter of Multiple Sclerosis will provide a means of funneling records so that more and better data can be accumulated as to diagnosis and treatment results.

On motion of Doctors Tenney–Hemmingsen, carried, the Council expressed its approval to this movement in Wisconsin.

15. Legislation on Pharmacy Prescription Pads

The Wisconsin Pharmaceutical Association would like to have a law passed under which pharmacists would be prohibited from distributing prescription pads with the name of the pharmacy on them. The Interim Committee recommended to the Council that the suggestion that the Society assist in this legislation be returned to the Pharmaceutical Association as one to be handled within its own group.

On motion of Doctors Ekblad–Christofferson, carried, this recommendation was returned to the Wisconsin Pharmaceutical Association.

16. Evaluation of Osteopathic Schools

After the last meeting of the Council, the secretary's office was asked to secure a statement from the State Board of Medical Examiners as to the procedure followed by the Board in evaluating osteopathic schools. The Board reported that it would be unable to make any personal examination of the individual schools as that would require time and expenditure of money which the Board does not have. Its decision on schools is made after correspondence with examining boards in Indiana, New York, Ohio and other states.

The Interim Committee felt that a different type of evaluation more consistent with the evaluation of medical schools is necessary to give assurance that these men have training equivalent to graduates of recognized medical schools.

On motion of Doctors Dessloch–Galasinski, carried, the Council asked that the advice of the Council on Medical Education and Hospitals of the American Medical Association be sought.

17. Life Membership

On motion of Doctors Galasinski–Wegmann, carried, life membership was approved for Dr. A. J. Patek, Milwaukee.

18. Associate Membership

On motion of Doctors Kasten–McCarey, carried, associate memberships were approved for Drs. F. F. Bowman, Madison; M. F. MacRae, Milwaukee; O. W. C. Maercklein, Milwaukee; W. L. Stranberg, Milwaukee; J. F. Zivnuska, Milwaukee; W. L. MacKedon, Milwaukee; H. E. Fillbach, Baileys Harbor; H. Hendrickson, Green Bay, and O. H. Oberembt, Milwaukee.

19. Recommendation for Approval of Life and Associate Memberships Approved

Under the By-Laws, election to life and associate memberships is by Council action. In the great majority of cases, election is a formality only. As a practical matter, the delay from time of nomination to time of election results in holding the physicians' membership pending. The suggestion was made that if the councilors of the appropriate districts ap-

prove the nominations, the secretary act to so classify the member. On motion of Doctors Eck–Galasinski, carried, this suggestion was approved.

20. Report of Committee on Group Insurance

This committee reported on developments since the last Council meeting with regard to the program to provide a group disability and hospitalization policy for the membership of the Society. It unanimously recommended the following action by the Council:

a. Selection of the Provident Life & Accident Insurance Company of Chattanooga, Tennessee, to write the group disability and hospitalization policy.
b. Establish benefits of $75 a week for total disability from sickness or accident to age 70, and benefits of $50 a week for ages 70–75.
c. Inclusion of hospitalization benefits of $10 a day up to 70 days per disability, and extra hospitalization charges up to $100 per disbility, for subscriber physicians only and not for their families. The insurance company requires either that all physicians subscribing to the plan take hospital benefits or that this coverage be available to none of them.
d. Payment of flat annual rate of $116 by members of all ages who would take the plan. Of this amount, $99 represents sickness and accidental coverage, and $17 hospitalization benefits for the member only. Step-up rates would vary between $93 and $155.
e. Require the company to submit copies of the proposed group contract and the membership certificates to the Society for analysis and approval well in advance of the date when the plan becomes effective, thereby minimizing any danger of misunderstanding on the part of the Society or insured members.
f. Authorize any two officers to execute the group application and any other papers required for installation of the plan.
g. Continue the Committee to Study Group Insurance in operation for purposes of correlating the installation of the plan and of acting as a review board in disputed cases thereafter.

On motion of Doctors Hemmingsen–Ekblad, carried, the Council approved the recommendations of the Committee to Study Group Insurance to establish benefits of $75 a week for total disability and to include hospitalization benefits.

21. Resignation of Doctor Kasten from Wisconsin Plan Committee

Dr. H. E. Kasten presented his resignation as a member of the Wisconsin Plan Committee, to be effective immediately. On motion of Doctors Ekblad–Christofferson, carried, the resignation was accepted.

22. Purchase of Furnishings Authorized for Dining Room

Doctor Arveson stated that it seemed most convenient to have meetings of the Council in the dining room of the Society's office building because of its larger size. He asked for authority to purchase chairs and to furnish the room suitably for Council meetings.

On motion of Doctors Kasten–Hemmingsen, carried, the Council authorized funds necessary to make purchases for the dining room as suggested.

23. Adjournment

The meeting adjourned at 12:40 p.m.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M.D.
Chairman of the Council

Wisconsin Anesthesia Study Commission

(Continued from page 724)

tration of anesthetic must be temporarily stopped. The patient must be adequately ventilated with oxygen. Intravenously administered barbiturates are often very useful in controlling the convulsions, but the establishment of ventilation is of prime importance to remove the narcotic concentrations of carbon dioxide and to restore tissue oxygenation.

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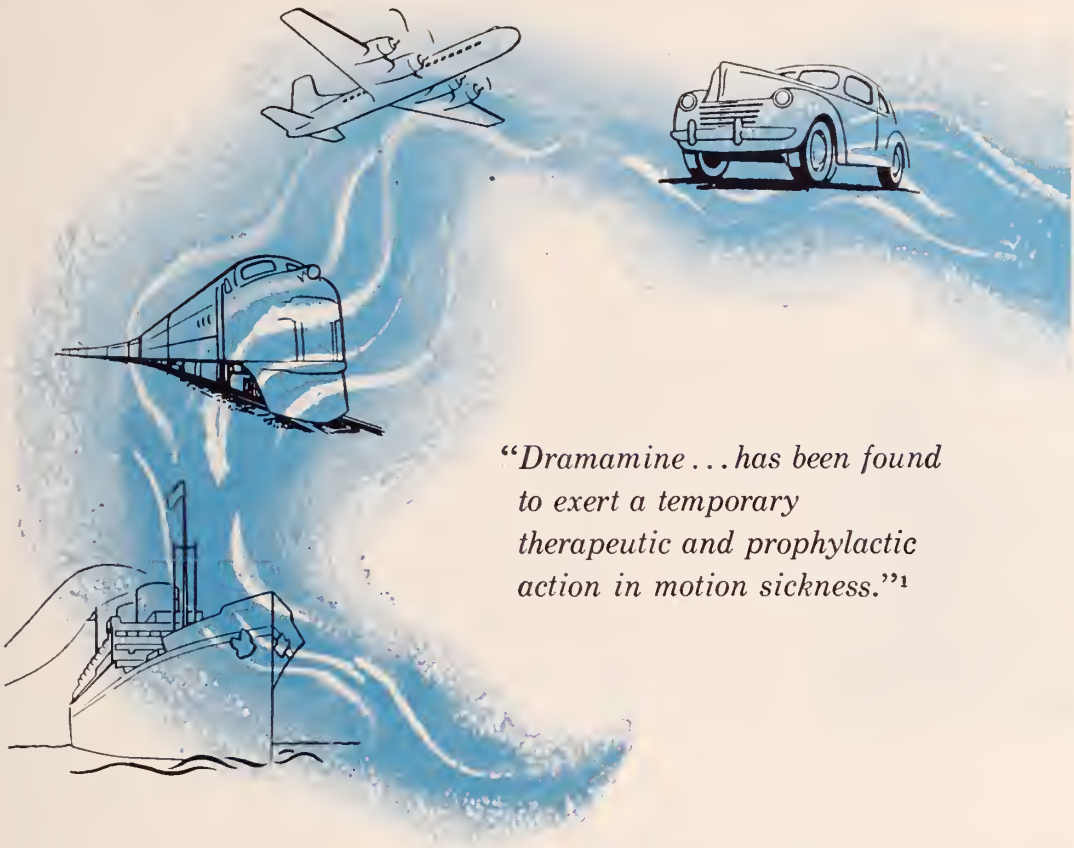
2. Pask, E. A.: Convulsions, Proc. Roy. Soc. Med. 35: 545–548 (June) 1942.

As It Looks to Your State Board of Health

(Continued from page 723)

mal values obtained from the initial pre-exposure samples. Through the establishment of this clinical control program, it will be possible to detect cases of incipient lead poisoning and to institute remedial engineering or ventilation control of the welding process and thus protect the health of the employees.

The Industrial Hygiene Division is equipped to evaluate the exposure of industrial employees to over 150 different toxic chemicals. The services of the division are available to industry, labor, or the medical profession upon request.—William L. Lea, Ph. D., *Director, Industrial Hygiene Division.*



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1. Council on Pharmacy & Chemistry: New and Nonofficial Remedies, 1950, Philadelphia, J. B. Lippincott Co., 1950, p. 460.

*Trademark of G. D. Searle & Co., Chicago 80, Ill.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

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Society Proceedings

Crawford

Members of the Crawford County Medical Society met at the home of *Dr. V. C. Epley*, Prairie du Chien, on June 22. A dinner was served by members of the Woman's Auxiliary.

Eau Claire—Dunn—Pepin

W. S. BUMP

A talk on research in cancer was presented before a meeting of the Eau Claire–Dunn – Pepin County Medical Society on June 26, when the group met at the Hotel Eau Claire in Eau Claire. Guest speaker was *Dr. Warner S. Bump*, Rhinelander, president of the Wisconsin Surgical Society.

Green Lake—Waushara

Meeting at the Hotel Whiting in Berlin on June 20, members of the Green Lake–Waushara County Medical Society heard a talk on "Preventing Behavior Problems in Children" by *Dr. H. Kent Tenney, Jr.*, of Madison. A number of nurses and teachers were also present to hear Doctor Tenney, who is an associate professor of pediatrics at the University of Wisconsin Medical School. At the business session which followed, a resolution was passed encouraging the formation of public health councils. The Society also voted to assist in sending a delegate from each of the two counties to the State 4-H Camp at Green Lake in September. A report was made by *Drs. Grant Stone*, Berlin, and *A. C. Theiler*, Princeton, on the proposed diabetes detection program, which is tentatively scheduled to be launched this fall.

Manitowoc

The annual election of officers highlighted the meeting of the Manitowoc County Medical Society at Wellhoefer's Sea Grill in Manitowoc on June 22. *Dr. Gerald Rau* of Manitowoc was named president, to succeed *Dr. George M. Simon*. *Dr. George Hoffman*, Manitowoc, will serve as vice-president; *Dr. George M. Simon*, also of Manitowoc, secretary-treasurer; and *Dr. John M. Kelley*, of Cato, censor.

Marinette—Florence

A discussion of intestinal obstructions was presented at a joint meeting of the Marinette–Florence and the Menominee (Mich.) County Medical Society on June 21 in the Riverside Country Club, Menominee. *Dr. C. S. Rife*, associate professor of surgery at Marquette University School of Medicine, was the guest speaker for the meeting.

Trempealeau—Jackson—Buffalo

Meeting at the MacCornack Clinic in Whitehall on July 27, members of the Trempealeau–Jackson–Buffalo County Medical Society heard a talk by *Dr. Robert M. Lotz* of Eau Claire. Doctor Lotz discussed "The Doctor, the Patient, and the Law."

Two members of the staff of the Marshfield Clinic in Marshfield were guest speakers at a meeting of the Society on June 23. Following a dinner at the new Freeman Hotel in Black River Falls, *Dr. John B. Miale* spoke on the pathology of carcinoma of the cervix and practical application of the Papanicolaou smear. *Dr. Paul Doege* then discussed carcinoma of the cervix with special reference to diagnosis and treatment.

Vernon

Dr. H. M. Coon, superintendent of the State of Wisconsin General Hospital, spoke at a meeting of the Vernon County Medical Society at the Casperson Tearoom, Viroqua, on June 21. His topic was "Hospital Administration, with Special Emphasis on the Importance of Keeping Adequate Medical Records." He had been requested to give his views on the most effective system of administration for the new Viroqua Memorial Hospital.

American Academy of General Practice Fond du Lac County Chapter

Dr. W. C. Finn, Fond du Lac, was named president of the Fond du Lac County chapter of the American Academy of General Practice at an organizational meeting held at the Takodah Country Club in Fond du Lac on July 25. Forty practitioners from the area were present for the presentation of the charter by *Dr. George E. Forkin*, Menasha, president of the Wisconsin chapter of the Academy. Officers who will serve with Doctor Finn are *Dr. Robert Schoen*, Beaver Dam, president-elect; and *Dr. Russell Pelton*, Markesan, secretary-treasurer. Guest speaker at the meeting was *Dr. E. C. Cary* of Reedsville, president of the Manitowoc chapter of the Academy. Other guests included *Drs. J. P. Canavan*, Neenah, past president of the state unit; *Dr. W. B. Hildebrand*, Menasha, secretary of the Wisconsin Academy and a member of the national board of directors; *Dr. A. H. Heidner*, West Bend, Councilor of the Fifth District of the State Medical Society; *Dr. C. C. Gascoigne*, Kohler, president of the Sheboygan chapter; and Drs. H. N. Hines and *R. G. Welsch*, officers of the Sheboygan chapter.

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Gallbladder Surgery, Ten Hours, starting October 23.
Fractures & Traumatic Surgery, Two Weeks, starting October 9.
Basic Principles in General Surgery, Two Weeks, starting September 11.
GYNECOLOGY—Intensive Course, Two Weeks, starting September 25.
Vaginal Approach to Pelvic Surgery, One Week, starting September 18.
OBSTETRICS—Intensive Course, Two Weeks, starting September 11.
MEDICINE—Intensive General Course, Two Weeks, starting October 2.
Gastro-enterology, Two Weeks, starting October 16.
Gastroscopy, Two Weeks, starting September 11 and October 23.
Electrocardiography & Heart Disease, Four Weeks, starting October 2.
DERMATOLOGY—Formal Course, Two Weeks, starting October 16.
Informal Clinical Course every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting September 25.
Cystoscopy, Ten Day Practical Course, every two weeks.
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John E. Leach, M. D.
George F. Meisinger, M. D.
Lloyd F. Jenk, M. D.

News Items and Personals

State Board of Health Reelects Officers

Dr. Stephen E. Gavin, Fond du Lac, and *Dr. Samuel L. Henke*, Eau Claire, were re-elected president and vice-president of the State Board of Health for one year terms at a meeting of the board held in Madison on July 31. Doctor Gavin has served on the board since April 1943 and has been its president since October 1948. Doctor Henke has been a board member since March 1947 and vice-president since October 1948.

Five three-year appointments were made to the Advisory Hospital Council as follows: *Dr. Harold M. Coon*, Madison, superintendent, Wisconsin General Hospital, reappointed to represent hospital administrators; *Dr. H. A. Sincock*, Superior, to succeed *Dr. J. W. Prentice*, Ashland, representing physicians; Mrs. Otto L. Falk, Milwaukee, to succeed William J. McNally, New Richmond, representing consumers of hospital services; Paul Bjerke, Luther Hospital pharmacist, Eau Claire, reappointed to represents pharmacists; and Dr. Wade R. Plater, Madison, to succeed Dr. R. P. Gingrass, Milwaukee, representing dentists.

Legionnaires Honor Dr. F. X. Pomainville

A testimonial dinner honoring *Dr. F. X. Pomainville*, Wisconsin Rapids, was given by the American Legion post of that city on May 22 at the Legion Clubhouse. More than 100 Legionnaires and townspeople attended, to pay tribute to the doctor for his many contributions as a public official and a private citizen, and he was presented a plaque bearing the following inscription: "Presented by Hagerstorm–Rude Post No. 9, American Legion, May 22, 1950, to Dr. F. X. Pomainville, the Grand Old Man of the Legion, for Distinguished, Unselfish Service Above and Beyond the Call of Duty."

The doctor, who has been a physician at Wisconsin Rapids for more than fifty years, was mayor of the city in 1909–1910, served as president of the board of education, and has been city health officer since early in the century. During World War I he served with the Army Medical Corps, holding the rank of major. He was a charter member of the local post of the American Legion and served as its commander in 1921 and again in 1925.

Coroners Association Names Officers

Dr. Theodore Teitgen, Manitowoc, was named president of the Wisconsin Coroners' Association at its annual meeting in Milwaukee, June 21. Serving with Doctor Teitgen will be *Dr. David Atwood*, Madison, vice-president, and Mr. Joseph A. La Monte, Milwaukee, secretary. *Drs. E. L. Tharinger*, Milwaukee County medical examiner, and *George Reay*, La Crosse, were elected to the executive committee.

Dr. E. F. White Named Medical Director of State Sanatorium

The appointment of *Dr. Ellison F. White*, Hawthorne, as medical director of the Wisconsin State Sanatorium, Statesan, was announced on July 11 by *Dr. Carl N. Neupert*, secretary of the State Board of Health. The appointment is effective September 1. Doctor White, who is at present superintendent and medical director of the Middle River Sanatorium at Hawthorne, will succeed *Dr. Richard H. Schmidt*, who recently resigned. A graduate of the University of Tennessee College of Medicine, from 1944 to 1947 Doctor White worked in the field of tuberculosis research at the Mayo Foundation, Rochester, Minn. During this period he was awarded an M. S. degree in medicine by the graduate school of the University of Minnesota.

Monroe Physician Addresses South American Meeting

Dr. W. B. Gnagi, Monroe physician, was on the program of the convention of the International College of Surgeons held in Buenos Aires, Argentina, August 1–4. His subject was "Indications for Surgery in the Treatment of Duodenal Ulcer." Accompanied by Mrs. Gnagi, he stopped at Rio de Janeiro, Santos, Brazil, and Montevideo, Uruguay, en route to the meeting and visited at Lima, Peru, and Panama on the return trip.

Marshfield Clinic Lists Two New Staff Members

Two physicians have recently been added to the staff of the Marshfield Clinic in Marshfield: *Dr. Norman J. Helland*, a former resident at the State of Wisconsin General Hospital, is associated with the department of urology; and Dr. Richard J. Rowe, who recently completed a residency at the University of Michigan Hospitals, Ann Arbor, Mich., is in the department of dermatology. Both are graduates of the University of Wisconsin Medical School.

Public Health Officials Attend Institute

Three Wisconsin public health officials attended an institute in administration principles and practices at Northwestern University July 17–29.

They are *Dr. Allan Filek*, director, local health administration, State Board of Health, Madison; *Dr. C. K. Kincaid*, city health commissioner, Madison; and *Dr. Garland Weidner*, city health officer, La Crosse. The institute was sponsored by Northwestern University and the United States Public Health Service and dealt with administrative problems and trends in public health.

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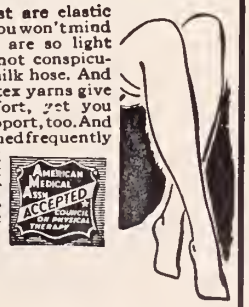

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AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

University Establishes New Medical Department

University of Wisconsin regents on July 15 voted to set up a separate department of the history of medicine in the University of Wisconsin Medical School, Madison. The new department will be headed by Dr. Erwin H. Ackerknecht, who came to the University in January 1947, as its first professor of the history of medicine. Doctor Ackerknecht, at one time the only full professor of medical history in the nation, was born in Germany and received his medical degree at the University of Leipzig in 1931. From 1933 to 1939 he studied at the Sorbonne in Paris to receive a degree of diplomate of ethnology. He came to the United States in 1941 after a stint in the French army. In this country he was associated with the Museum of Natural History in New York and Johns Hopkins University prior to coming to Wisconsin.

Dr. M. N. Golper Enters Practice in Texas

Dr. Marvin N. Golper, a graduate of the University of Wisconsin Medical School, recently completed a three year residency in radiology at the State of Wisconsin General Hospital. On August 1 he joined Dr. Vincent M. Ravel in the practice of radiology in El Paso, Texas.

Third District Physicians Speak at Mental Health Conference

Among the speakers at a two day mental health institute at Whitewater State Teachers College, July 19–20, were *Drs. Hertha Tarrasch* of the Rock County Health Center, Janesville, and *H. Kent Tenney*, Madison pediatrician. Doctor Tarrasch spoke on "The Relationship between the Physical and Mental Health of Children," and Doctor Tenney discussed "The Emotional Development of Children." The institute was sponsored by Whitewater State Teachers College, the United States Public Health Service, and Wisconsin county welfare departments.

SOCIETY PROCEEDINGS

Rock

Dr. J. W. Truitt, president of the State Medical Society, was the guest speaker at a joint meeting of the Rock County Medical Society and its Auxiliary at the Hotel Hilton on May 23. His talk was entitled "The President Thinks Aloud."

Four resolutions presented by the Committee on Public Relations were also passed by the group. They read as follows:

Resolution on Compulsory Socialized Medicine

The Rock County Medical Society is cognizant of the fact:

(a) That national socialized medicine is a part of a left-wing drive for total socialism in this country which would lead inevitably to totalitarianism.

(b) That the United States leads the world in medicine under the American system.

(c) That national socialized medicine would provide poor care for the sick; that bureaucrats would step in and run the doctors' practice; that patients would no longer be able to pick their own physicians; that doctors would waste time filling out forms and coping with government red tape.

Therefore, be it resolved, that the Rock County Medical Society go on record as being unalterably opposed to national socialized medicine.

Be it further resolved that a copy of this resolution be sent to the Wisconsin State Medical Society.

Lay Participation in Medical Society Activities

The Rock County Medical Society recognizes that the administration of the practice of medicine with its sociological and economic aspects is no longer an exclusive right of doctors of medicine.

It is felt that because of the increasing complexities of society, where more and more the various trades and professions are inter-dependent upon each other, it naturally follows that their problems more and more become the concern of all those that are involved. The public who pays the bill has a right to know something about how the doctors arrive at the various formulas for handling of their administrative and economic problems.

By the same token physicians have a right to know something about the processes that go on in lay organizations having for their primary objectives the health of their members.

Therefore, be it resolved, that the Rock County Medical Society approve in principle that lay individuals be appointed in an advisory capacity on appropriate committees of the Rock County Medical Society.

Be it further resolved that the Committee on Public Relations, Legislation and Public Health of the Rock County Medical Society be authorized to determine what constitutes such appropriate committees and to provide for the appointment of lay individuals to include representatives of labor and management as advisory members of such committees.

Budget Resolution

The strategy on the part of the American Medical Association in fighting Socialized Medicine has been to decentralize its efforts and bring them down to the "grass roots." This has put a greater responsibility upon the state organization and a greater responsibility on the county units.

The effort of the county medical societies must increase in tempo if the over-all plan is to succeed. County societies must gear themselves to ever increasing and relentless activity.

The increased activities will mean over-all planning on the part of officers, better and actively functioning committees and, moreover, increased funds.

Therefore, be it resolved that the Rock County Medical Society create a Budget Committee to consist of five members appointed by the president of that Society. This committee shall meet no later than thirty days before each annual meeting to prepare a budget of probable income and probable expense.

They shall designate the time and place of this meeting and grant a hearing to anyone wishing to appear before them.

The Budget Committee shall present the budget at the annual meeting together with any such comments and recommendations as are deemed advisable.

Woman's Auxiliary to Rock County Medical Society

The Rock County Medical Society realizes fully that the practice of medicine in the United States is being threatened through the efforts of the social planners in Washington.

It is fully aware of the fact that the time has come when all friends of the Free Enterprise System must really rally to the support of that system if it is to continue to exist. This includes all individuals and all groups and all organizations who love America and that for which it stands. Medicine constitutes the first ramparts against the attack of the social planners. If it falls, all will fall with it.

It is recognized over the entire United States that the women of auxiliaries to medical societies have within their organizations an unlimited capacity to assist the medical organizations in creating good public relations, fostering good will and aiding in the dissemination of important and necessary information as to the evil impact of socialization of medicine on the public.

Therefore, be it resolved, that the Rock County Medical Society reaffirm its belief and confidence in the worth-whileness of the medical auxiliary as

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an important and necessary ally in its fight against socialized medicine.

Furthermore, be it resolved, that the Rock County Medical Society through its specially constituted committee will give the Woman's Auxiliary all the aid within its power to carry out the objectives for which it was created.

TWELFTH DISTRICT NEWS

Milwaukee Pediatrician Addresses Montana Physicians

Dr. M. G. Peterman, Milwaukee pediatrician, addressed the Montana State Pediatric Society at Bozeman, Montana, on July 10. His subject was "A Study of Developing Epiphyseal Centers in Children." He also spoke before the convention of the Montana State Medical Society at Bozeman, July 10–12, on "Convulsions in Children," "The Treatment of Epilepsy," and "Infant Feeding."

SOCIETY PROCEEDING

American Academy of General Practice Milwaukee Chapter

Dr. Philip Thorek, Chicago surgeon, spoke on the subject of jaundice at a dinner meeting of the Milwaukee Chapter of the American Academy of General Practice at the Astor Hotel, Milwaukee, on June 22. Doctor Thorek is clinical assistant professor of surgery at the University of Illinois College of Medicine and associate professor of surgery at the Cook County Graduate School of Medicine.

SOCIETY RECORDS

New Members

Robert A. Moses, Levin–Delavan Clinic, Delavan.

G. V. Muscato, Jr., 5103 North 126th Street, Butler.

J. D. Teigland, Veterans Administration, Wood.

G. N. Spencer, Veterans Administration, Wood.

R. J. Krill, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee.

Mary P. Gratiot, Shullsburg.

J. N. Richards, 1300 University Avenue, Madison 6.

Frank Springer, Elmwood.

W. J. Little, Statesan.

Roger I. Bender, Beaver Dam.

R. F. Boock, Beaver Dam.

C. J. Buscaglia, 2778 North Seventy-Third Street, Milwaukee 10.

E. H. Carstens, Rib Lake.

J. E. Conway, 144 Main Street, Menasha.

J. P. Fetherston, Jr., 2218 North Third Street, Milwaukee 12.

G. A. Grindell, Siren.

M. O. Hamel, Medical Director, Red Cross Blood Center, Madison.

Hans Hartenstein, Cook County Hospital, Chicago, Illinois.

D. V. Moffet, Crandon.

C. A. Sattler, 2209 Sixty-Third Street, Kenosha.

R. E. Urbanek, Beaver Dam.

G. R. Weber, Kenosha Bank Building, Kenosha.

Lawrence Wolf, 2860 North Forty-Fourth Street, Milwaukee.

Changes in Address

D. E. Wynegar, Wauwatosa, to Veterans Administration, Knoxville, Iowa.

H. A. Weisse, Dallas, Texas, to Plymouth Clinic, Plymouth.

E. W. Woods, Wood, to 2915 Sixteenth Street, Racine.

M. W. Monroe, Wood, to 2579 North Maryland Avenue, Milwaukee 11.

D. L. Taber, Milwaukee, to Norwalk Hospital, Norwalk, Connecticut.

B. C. McLaughlin, Philadephia, to 3551 North Downer Avenue, Milwaukee 11.

R. R. Liebenow, Stevens Point, to 113 West Lake Street, Lake Mills.

W. E. Clasen, Pueblo, Colorado, to Central Clinic, 402 Davenport Bank Building, Davenport, Iowa.

J. L. Teresi, Milwaukee, to 901 Michigan Avenue, Waukesha.

Helen S. Marshall, Seattle, Washington, to Statesan.

William Merkow, Milwaukee, to Waukesha.

W. J. Madden, Milwaukee, to 810 South Main Street, Racine.

J. T. Schmitz, South Milwaukee, to 4204 North Stowell Avenue, Milwaukee.

H. O. Caswell, Glen Ellyn, Illinois, to Forest Lawn Sanatorium, Jefferson.

R. E. Schmidt, Wauwatosa, to 4240 West Derley Place, Milwaukee 8.

E. F. White, Hawthorne, to Statesan.

Alfred Wallner, Van Nuys, California, 5929 Wardlow Road, Long Beach 8, California.

G. Walter Marbry, Monroe, to Cheyenne, Wyoming.

F. D. Cook, Chippewa Falls, to Steves, Halgren, and Long Clinic, Menomonie.

W. G. Smirl, Eagle, to Memorial Hospital, Van Buren Street, Wilmington, Delaware.

F. E. Schlueter, Wellesley Hills, Mass., to 65 North Madison Avenue, Pasadena, California.

M. A. Cornwall, St. Paul, Minn., to Hudson.

N. J. Helland, Madison, to Marshfield Clinic, Marshfield.

Edward Zupanc, Madison, to Medical Arts Building, Duluth 2, Minnesota.

N. M. Golper, Madison, to 616 Mills Building, El Paso, Texas.

MARRIAGE

Dr. Kenneth A. Bittle to Miss Jeanne Ann Weigel, Milwaukee, on June 7.

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BIRTHS

A son to Dr. and Mrs. Leif H. Lokvam, Kenosha, on May 30.

A daughter to Dr. and Mrs. Kenneth A. Seifert, Wauwatosa, on July 26.

DEATHS

Dr. Louis J. Simon, 67, Fond du Lac physician, died suddenly at his home in that city on June 26. He had practiced medicine for forty-two years.

Born at Johnsburg on April 13, 1883, he received his medical degree from the University of Illinois College of Medicine in 1908. That year he began practice in Horicon, moving to Fond du Lac in 1919. From 1934 to 1947 he was physician for the Fond du Lac County Asylum and Home.

Doctor Simon was a member of the University of Illinois Alumni Association, the Fond du Lac County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife, two daughters, and a son.

Dr. William E. H. Teich, a retired Wisconsin physician, died on June 17 at a Milwaukee hospital. He was 82 years old.

Born at Watertown on March 17, 1868, the doctor received his M. D. degree from the Milwaukee College of Physicians and Surgeons. He began his medical practice at Watertown, later moving to Hustisford, Gresham, Bonduel, and Cecil.

Doctor Teich is survived by a daughter.

CORRESPONDENCE

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Wausau, Wisconsin, June 21, 1950

Dear Sir:

I think one of the most forward looking steps which has been taken in medical circles in many a day is the action written up in your June, 1950, issue, of the Rock County Medical Society in having lay participation on some of its committees.

I have advocated such a move for many a day and I don't think there is anything that will bring more public support in this fight against socialized medicine than to advise with lay people in each community.

After all, lay people don't generally read articles on medical practice, but when you have lay people who can tell their friends what is actually going on and what the score is, then you will really bring your message home as you can't do in any other way.

It so happened that within the past week and before seeing this item I wrote one of my friends in the A.M.A. office in Chicago and again urged that something be done along these lines.

My congratulations to Rock County.

Yours very truly,
(signed) B. E. KUECHLE
Vice-President and Claim Manager

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Robert D. Brookes, M. D.
Archie D. Carr, M. D.
Arthur H. Deppe, M. D.
Sydney B. Maughs, M. D.
Hans B. Molholm, M. D.
Walter L. Moore, M. D.

The Journal Bookshelf

Operations of General Surgery. By Thomas G. Orr, M. D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas. Second edition. Pp. 890, with 721 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $13.50.

The second edition of "Operations of General Surgery" by Doctor Orr follows the same general principles as the first edition. Many additions and some changes have been made, due to the tremendous increase in interest in certain fields of surgery in the past five years. Particularly is this noted in the chapters on thorax, the circulatory system, and congenital diseases. Doctor Orr has been extremely careful to include those new works in general surgery which has proved their worth and are now part of the surgeon's armamentarium.

This text has a place in the library of every surgeon and surgical resident, for its presents the standard and proved operations from which the young surgeon or surgeon with little experience in a particular field may find many fine procedures and technics. Too often surgical texts have so many technics that unless one is experienced in the field there may be considerable confusion. The printing and drawings are of the highest quality, and each operation is described in detail.—A.R.C.

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: General electric portable shockproof x-ray unit in excellent condition at ⅓ of list price. One new mobile 30 MA, 96 PKV, Fischer shockproof x-ray unit at $795. One new Fischer short wave with hinged drum electrode and arm, FCC type approved, $355. One used Jones metabolism unit guaranteed accurate at one-half price. One new style Hyfrecator used only a few months, at marked reduction. One used direct writing electrocardiograph at about one-half price, factory reconditioned. C. C. Remington, 720 North Jefferson Street, Milwaukee 2. Telephones Daly 8-6368 and Woodruff 2-4028.

WANTED IMMEDIATELY by midwestern group: Urological assistant. Salary $400 per month. Minimum requirements: rotating internship. Address replies to Mr. Louis F. Chess, Business Manager, Medical Associates, 1200 Main Street, Dubuque, Iowa.

FOR SALE: General practice. Owner retiring after 39 years in the same location in northeast Wisconsin community of 3,500. Home, office, and equipment for sale. Good location, good schools and churches. Can easily be made a partnership. Address replies to No. 290 in care of the Journal.

WANTED: EENT man or ophthalmologist capable of doing refractions for association in clinic in busy Wisconsin area. Address replies to No. 300 in care of the Journal.

FOR SALE: Country practice in northwest Wisconsin. No competition. Modern residence, ideally located. Annual dairy income in territory. Nothing to buy but five bed room residence, with office room, waiting room, and laboratory in residence. Separate parking and sidewalk to waiting room. Spacious lawn, foliage, and ideal residence. Young man can use extra rooms for hospital rooms. Selling reason: coronary thrombosis. Address replies to No. 170 in care of the Journal.

AVAILABLE: Physician, 35 as locum tenens until December 31, 1950, when begins final year of radiology residency. Background of 3 years' general practice. National Boards, Wisconsin license. Address replies to No. 325 in care of the Journal.

WANTED by well established older F.A.C.S.: A general practitioner for assistant. Married man preferred. Good hospital facilities; salary first six months, then percentage. Apartment available. Suburban area of Twin Cities. Great opportunity for future. Minnesota license or National Boards required. Address replies to No. 303 in care of the Journal.

FOR SALE: Practice and equipment of deceased physician in community of 1,000. Office for rent. Hospital facilities within 15 miles. Address replies to No. 310 in care of the Journal.

FOR RENT: Office of the late Dr. Charles R. Treat, Sharon, Wisconsin. Office fully furnished. Instruments for sale. Call or write to Mrs. Charles R. Treat, Sharon, Wisconsin.

ASSOCIATE WANTED: For general practice in northwest Wisconsin city of 2,500. Dairy farming community 90 miles from Twin Cities. Age up to 35. Especially interested in someone with one or two years' general practice experience or just finishing internship. Address replies to No. 311 in care of the Journal.

WANTED: Assistant to eventually be associate, either E.E.N.T. or E.N.T. State age, experience (need not be full fledged specialist) and stipend expected. Address replies to No. 312 in care of the Journal.

PHYSICIAN'S OFFICE AND EQUIPMENT for rent or sale. Prominent old established location. Retiring from practice. Dr. Bernard Krueger, 3552 East Layton Avenue, Cudahy, Wisconsin.

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FOR SALE: Long established eye and general practice located 15 miles north of Madison. Home-office included; terms. Physician deceased. Write to Mrs. A. P. Wenger, De Forest, Wisconsin.

PHYSICIAN WANTED: Physician associate with two other doctors in Twin City area of Wisconsin. General practitioner or preferably man with additional obstetric training. Excellent hospital facilities. Address replies to No. 316 in care of the Journal.

AVAILABLE: Experienced general practitioner desires association or independent practice in medium-sized city with hospital facilities. Address replies to No. 315 in care of the Journal.

LOCATION WANTED: 40 year old physician would like to do general practice in a city of 5,000 to 15,000. Have ample funds to invest. Prefer city in southern Wisconsin with good hospital facilities. Address replies to No. 319 in care of the Journal.

FOR SALE: Physician's surgical instruments, autoclave, combination operating and OB table, 2 oxygen regulators, examinating and dressing tables, hand drill with chuck attachment, 4 dozen assorted aluminum splints, metal traction bow, etc. Address replies to No. 320 in care of the Journal.

LOCATION WANTED: Young physician, 25, married, licensed in Wisconsin, recently completed internship, seeking location for general practice in smaller Wisconsin community or position as assistant to busy general practitioner. Address replies to No. 302 in care of the Journal.

FOR SALE: General practice and office equipment in prosperous southern Wisconsin at Brodhead. Excellent hospital facilities available. Only one other physician in active practice. Very reasonably priced but is a real opportunity. Reason for leaving: taking residency. Contact Dr. F. D. Swan, Augustana Hospital, 411 West Dickens, Chicago 14, Illinois.

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AVAILABLE: Internist, Board qualified, age 30, married, completing 3 year residency at large teaching institution. Desire association with individual or group, full time or part time. Will consider buying practice. Wisconsin license. Address replies to No. 322 in care of the Journal.

FOR RENT Small office in a doctor's suite which is very well equipped. Excellent location downtown Milwaukee. Address replies to No. 323 in care of the Journal.

PHYSICIAN WANTED as an assistant and later as a partner to a well established general and surgical practice in a city in south-central Wisconsin. Excellent hospital. Physician, the owner, has a well equipped clinic building. Address replies to No. 326 in care of the Journal.

AVAILABLE IMMEDIATELY: Wonderful opportunity, excellent, well established general practice in Milwaukee. Leaving due to illness. Well equipped, newly decorated, beautiful office; should gross $25,000–$30,000 first year. Lease available. Five large rooms, 800 square feet of space. Equipment includes 100 milliampere x-ray, 3 examining tables, short-wave, ultraviolet, infra-red, EKG, basal, and refrigerator for biologicals Address replies to No. 327 in care of the Journal.

FOR SALE: Instruments and equipment of deceased physician. Address replies to No. 328 in care of the Journal.

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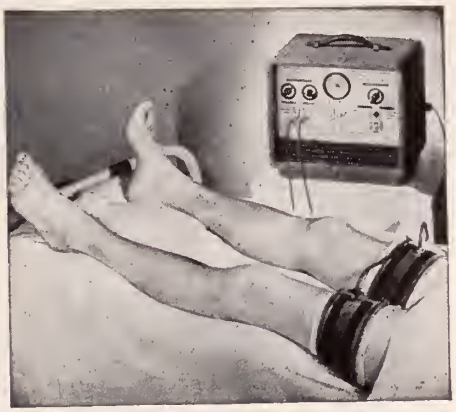

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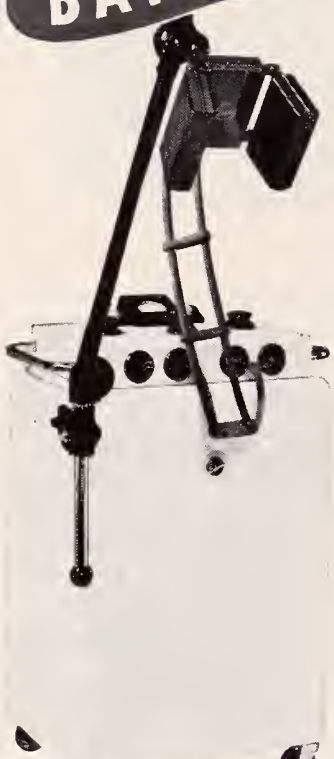

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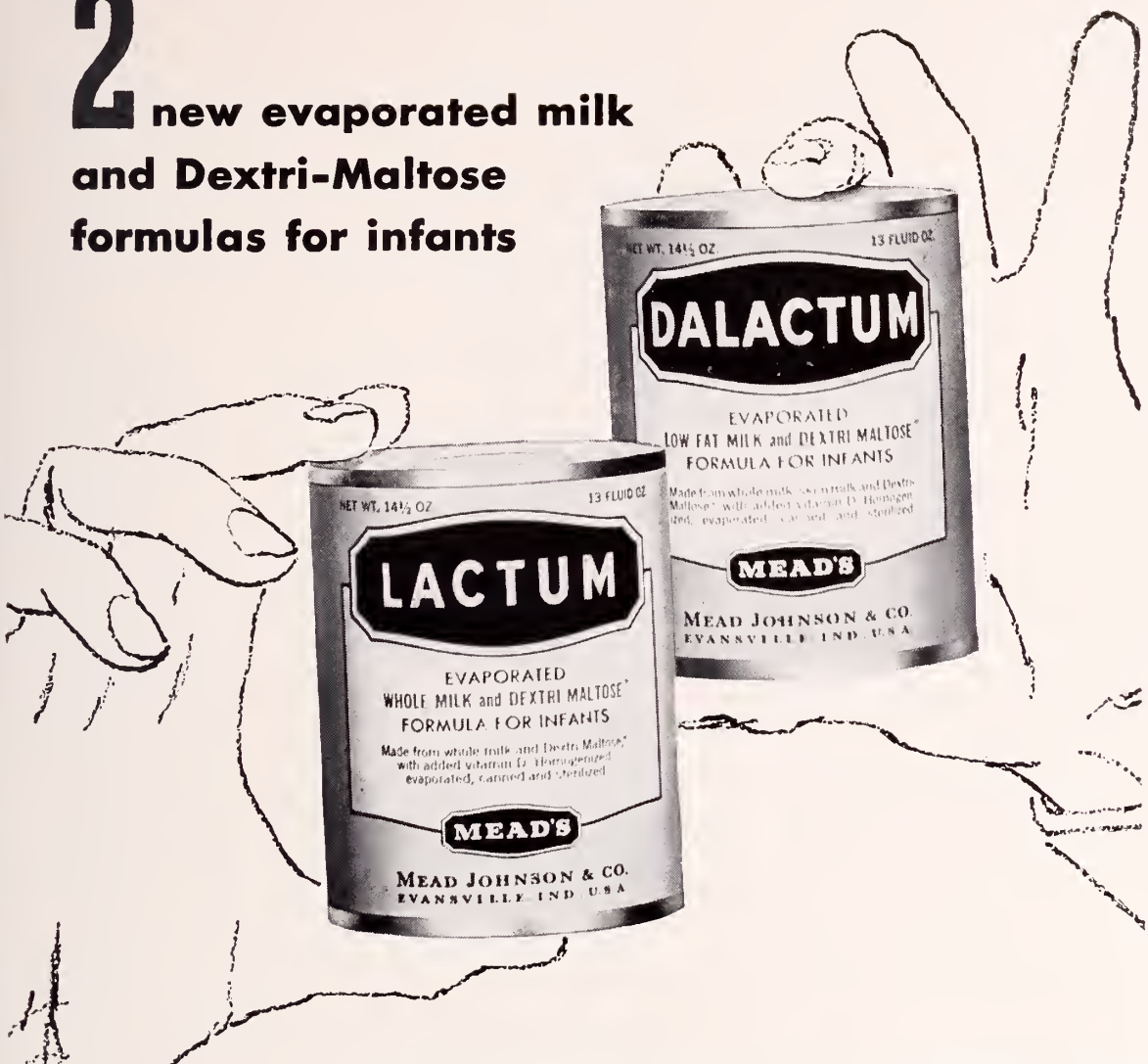

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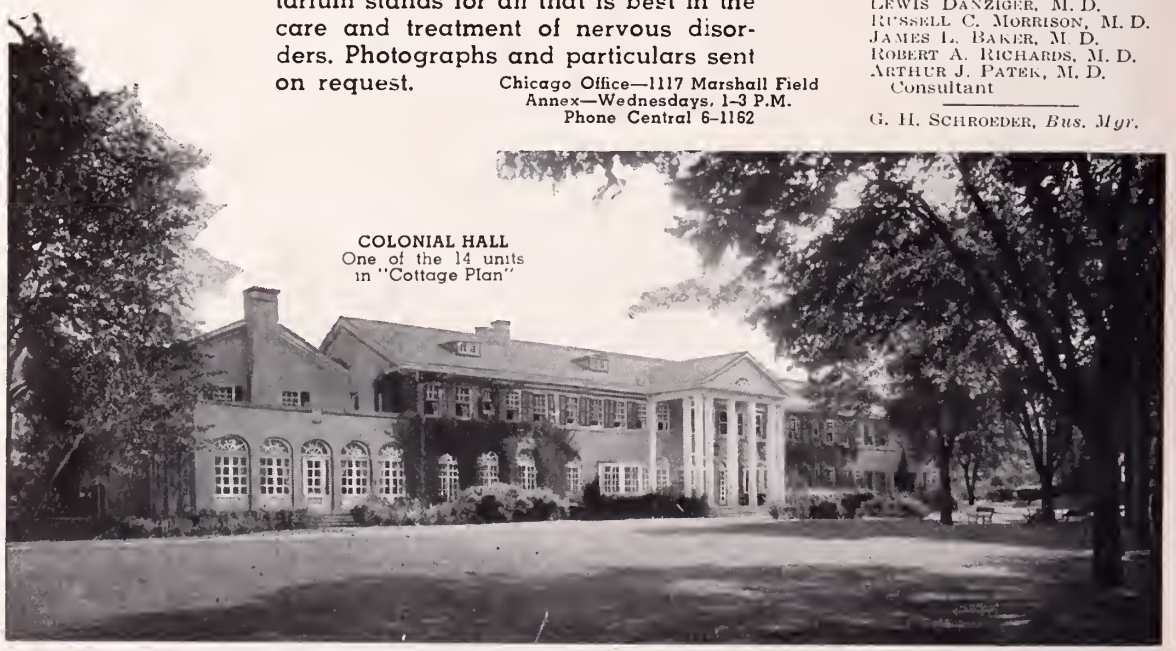

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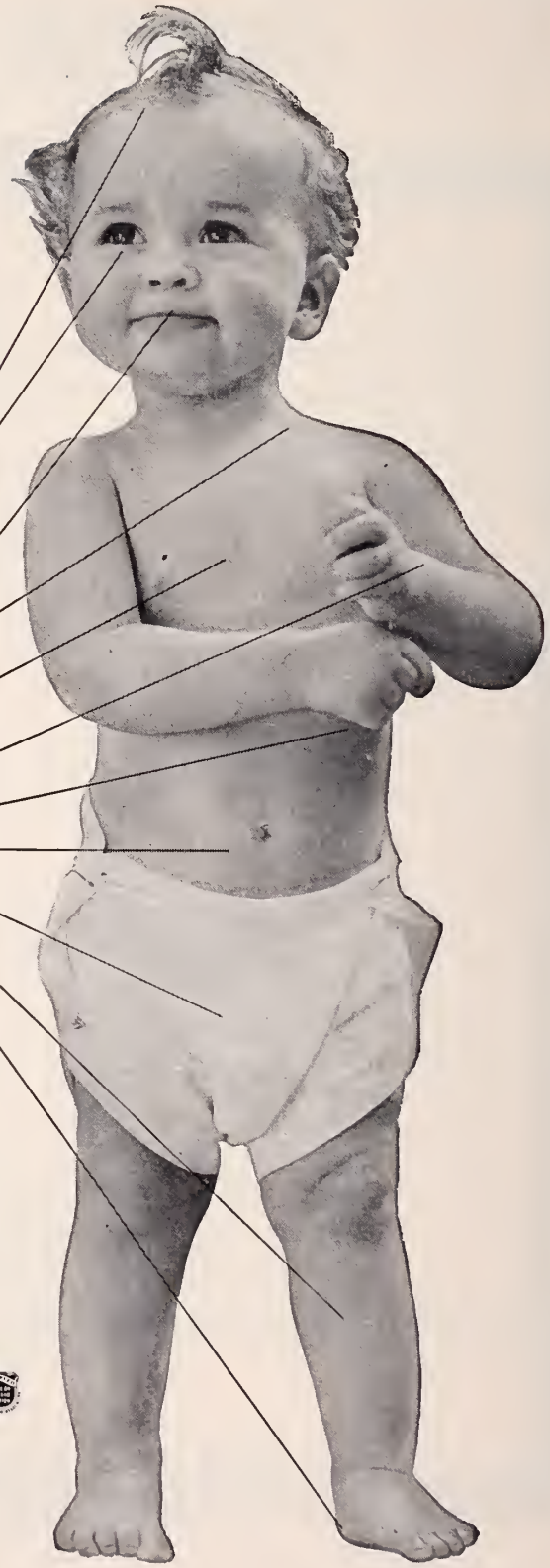

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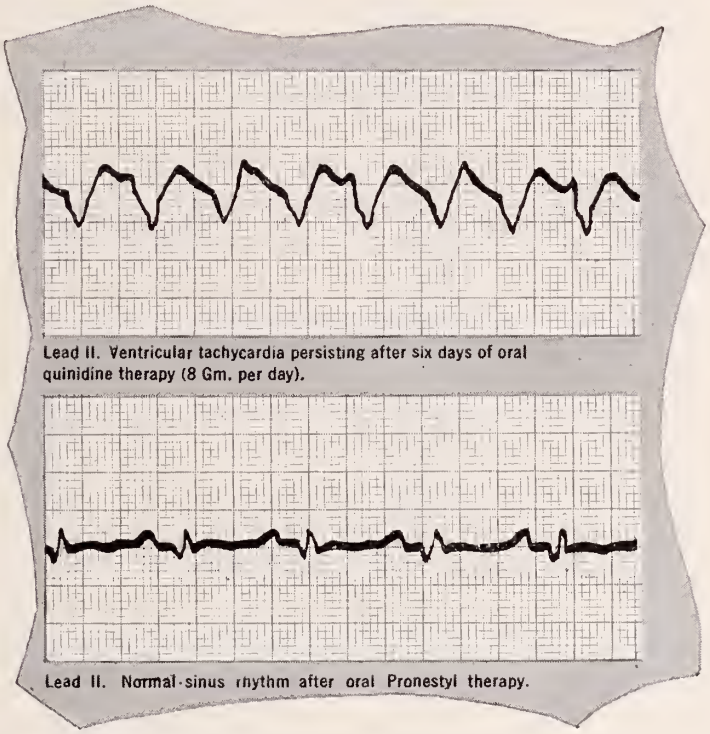

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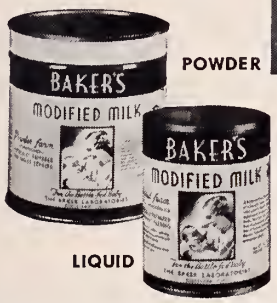

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« « « EDITORIALS » » »

Histoplasmosis

This disease is one of the relatively new diseases in the list of human ailments. The organisms were first described in 1906 as an intracellular form. It was first isolated and found to be a fungus in 1933–1934 by Hansmann and Schenken. Little has been known of the frequency of the distribution of the disease throughout the United States until the last several years. Even now information is incomplete on this subject. The first suggestion that it might be an important disease came from a survey of school children in certain southern states to detect pulmonary tuberculosis. This survey was carried out by routine chest examinations and the tuberculin skin test. Much to the surprise of the investigators, the tuberculin test was found to be negative in many patients in whose x-ray plates lung infiltrations were found. This appeared to contradict the long standing observation that sensitization to tuberculin endured throughout lifetime, and suggested that the tuberculin test is not reliable to establish the incidence of tuberculosis in the population. After several years of further study, the conflict between the x-ray plates and the tuberculin test in these surveys was explained by recognition of the pathology of histoplasmosis and confidence in the tuberculin test was restored. The confusion between tuberculosis and histoplasmosis is the result of the similarity of syndrome and not etiology. Thus the clinical entity is an expression of an etiologic diversity.

In this connection the studies of Furcolow* and his associates on histoplasmosis with reference to its etiology are of interest to the doctor. In a recent issue of *Public Health Reports*, he gives the case histories of 16 cases of histoplasmosis found in the states bordering the Mississippi River and especially in the area around Kansas City. Six of the case reports are for new cases and 10 are follow-ups on previously reported cases.

On the basis of a positive skin test to histoplasmosis, calcified areas in the lung and hilar lymph nodes and a negative tuberculin test, the conclusion is reached that the largest number of people who are affected by H. capsulatum fail to manifest clinical evidence of the disease. The investigation revealed that about 80 per cent of the population in the Kansas City area responded in a positive manner to histoplasmin. The case of a 13 year old boy is reported who in February 1945 came under observation as a result of a school survey in Kansas City. He was found to have miliary pulmonary infiltrations with

* Public Health Reports—August 4, 1950, Vol. 65, Number 31.

bilateral hilar adenopathy. In spite of his x-rays he was apparently in good health. The tuberculin reaction was negative and the histoplasmin positive. There was no elevation of temperature during a 10 day stay in the hospital where he was kept under supervision for laboratory examinations. In March 1950 this child was still in good health and attending school.

In contrast to the above case is a 4 year old child who came under observation with a diagnosis of pulmonary tuberculosis. He was acutely ill, as evidenced by an elevation of temperature, and the physical examination revealed an enlarged spleen, enlarged lymph nodes and lung infiltrations. The histoplasmin test was positive and the tuberculin test was negative. Two years after the first admission, the tonsils were removed and H. capsulatum was isolated. In December 1949, the patient had recovered and apparently was in good health.

This report is interesting reading and illustrates the similarity of signs and symptoms in two different diseases, and the difference in reaction to the infectious agent H. capsulatum by different people is brought out.

Put Up or Shut Up!

In every human undertaking, there comes a time for action, a time for decision. You can describe it in the language of the marriage service, or, if you prefer, of the poker table, "Put up or shut up."

No matter how you phrase it, the alternative of such a time cannot be denied.

This year is a time of decision that requires positive action on the part of the medical profession. If this action is not forthcoming, doctors cannot reasonably complain of the consequences.

After the surprise party which Mr. Truman threw in November 1948, some of the political leaders in Ohio decided to hold a postmortem. Records in one of Ohio's leading industrial areas show that 18 per cent of the physicians in the county did not vote in the 1948 election; 13 per cent were not even registered and, therefore, not eligible to vote. Twenty-two per cent of the wives of physicians did not vote. Eighteen per cent of the druggists did not vote, nor did 32 per cent of bank employees, 33 per cent of the ministers, 34 per cent of the retail grocers, and 21 per cent of the members of the Chamber of Commerce.

Strange as it may seem, elections are still won by votes, and the politician still has a warm spot in his heart for groups which vote and produce votes.

This is a year in which the American people elect Senators and Congressmen to represent them in Washington. Under our system of government, it is up to every citizen to work for the success of candidates in whose views he believes. Only through *active* effort can we have *good* government.

This responsibility is now squarely before all doctors. If they are to be well represented, they must work, and they must start now. Doctors, their families, their friends, all they can influence must be registered. On election day—in primary balloting and in November—it is up to the doctors to help turn out the vote—the vote for their candidates.

There is only one way to preserve American freedom—medical freedom—under our democratic process. That way is the voting way—the electioneering way. It is the best way ever devised, but it poses responsibilities.

They are responsibilities no doctor can afford to sidestep. They are responsibilities that need meeting . . . now . . . today.

The Journal Begins Publication of Reports of Clinicopathologic Conferences

Almost a year ago, at the suggestion of Dr. Karl Doege, then medical editor of the *Journal*, plans were formulated for the publication of reports of clinicopathologic conferences from Wisconsin hospitals. Beginning with this issue, that section will appear regularly, under the editorial direction of Drs. W. A. D. Anderson and D. M. Angevine, directors of the departments of pathology of the Marquette University School of Medicine and the University of Wisconsin Medical School respectively.

Pathologists throughout the state are invited to contribute reports of interest to this section, forwarding their suggested manuscripts to either of the two editors.

It is interesting to note that this is the fourth in a series of new sections to be added to *The Wisconsin Medical Journal* during the past year. The editorial section was introduced a year ago, followed by the publication of papers presented before the Milwaukee Academy of Medicine, reports of the Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists, and the present section, reports of clinicopathologic conferences.

Your comments on these features are invited.

Diagnosis in Chronic Liver Disease*

By M. C. F. LINDERT, M. D.
Milwaukee

M. C. F. LINDERT

Doctor Lindert, who maintains a private practice in internal medicine in Milwaukee, received his degree in medicine from the University of Minnesota Medical School in 1939. A diplomate of the American Board of Internal Medicine, Doctor Lindert is chief of staff at Milwaukee County General Hospital, an assistant professor of clinical medicine at Marquette University School of Medicine, and a consultant in internal medicine at the Veterans Administration Hospital, Wood.

THE acuity of one's diagnosis of chronic diseases of the liver is dependent upon the following factors: (1) a constant awareness of its occurrence; (2) the searching interrogation of past history and systemic inventory; (3) a detailed, observant physical examination; (4) an understanding of the fundamental physiology of liver function (and with it a correlation of the liver function tests), and (5) the utilization of diagnostic aids such as liver biopsy and peritoneoscopy. The first factor is self-explanatory and needs very little clarification. However, one cannot emphasize too frequently that a proper diagnosis may rest upon a physician's keeping the condition in mind. As in so many other diseases, the more conscious one is of the existence of hepatic ailment, the more likely the diagnosis can be made. It is assumed that all physicians have been duly alerted to the numerous diseases which may involve the liver as a primary or secondary process. This paper will concentrate on the four remaining factors.

Historical Features

The symptomatology of chronic liver disease has long been known. Those of the advanced state are easily recognized. However, it may be extremely difficult to evaluate a history of minimal or moderate involvement. Our knowledge of the symptom complex of the latter situation has been enhanced by the experiences in the epidemics of hepatitis during World War II, along with an apparent increased incidence of hepatitis since the war. The historical features that suggest the possible presence of liver disease are as follows:

1. *Gastrointestinal.*—These symptoms are secondary to changes in the biliary secretions, intestinal contents, and nutrition. Most predominant are those of flatulent indigestion, nausea, vomiting belching, and anorexia. The early morning nausea in alcoholic cirrhosis is a characteristic feature. Changes in bowel habit have been frequently noted, generally that of a change toward loose stools with the passage of an increased amount of flatus. These symptoms progress as the liver process becomes more advanced. The inability to digest fat and the occurrence of steatorrhea result from faulty fat digestion and from fat being secreted into the intestine.

2. *Easy Fatigability and Weakness.*—This is a uniform complaint in most instances. Some patients have been labelled as having neuropsychiatric disease because of these symptoms and an accompanying lack of physical findings. Several theoretic explanations have been given for this disturbing feature. It has been ascribed to a disturbance of carbohydrate metabolism, bile salt retention, sodium retention, vitamin E deficiency, or a disturbance of myoneural physiology. It may occur without accompanying weight loss or anorexia.

3. *Pain.*—This is a variable complaint. It may be manifested as a dull, heavy, dragging sensation in the right upper quadrant. A vague sensation of fullness or pressure is described by some. Finally, but rather unusual, is a sharp acute pain in the right upper quadrant or midepigastrium. In chronic hepatitis of viral origin the abdominal distress is more pronounced after physical exertion. This distress is promptly relieved by bed rest and has been employed as a significant sign indicative of active hepatitis.

4. *Jaundice.*—The subjective observation of icterus is not a constant feature of chronic liver disease but frequently is observed by others some time during the course of such an illness. One may be able to ascertain a history of recurrent bouts of jaundice lasting anywhere from one to several weeks. In the advanced processes the jaundice may develop and become progressively worse, terminating in a classic picture of cholemia.

5. *Accumulation of Fluid, Manifested by Ascites, Edema, Pleural Effusion, or Generalized Anasarca.*—These complaints are invariably associated with a long-standing disease or as evidence of decompensated liver function. Pleural effusion per se is not a complaint, but symptoms which suggest pleural effusion are; such as breathlessness, cough, and even a fullness in the chest.

6. *Hemorrhagic Phenomena.*—These may be manifested by gastrointestinal bleeding in the form of hematemesis and/or melena. The etiology of this may not always be due to the existence of varices, either esophageal or gastric, but may be due to acute diffuse gastritis or profound hypoprothrom-

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

binemia. There may be bleeding from hemorrhoids. Hemorrhage from other mucous membranes is not a uniform complaint but should be questioned in every case.

7. *Weight Change.*—This transition is toward the side of that of weight loss to correspond more or less with the degree of gastrointestinal complaints which have existed, especially that of anorexia. Here again, as the liver disease process becomes advanced, weight loss becomes a prominent feature and many times will exist in spite of the fact that ascites or accumulation of fluid in the tissues has occurred.

8. *Pruritus.*—This is likewise an inconstant feature but may exist as a preicteric symptom. Recently I have had the good fortune to observe 2 patients with primary hepatoma, 1 of whom also had portal cirrhosis, and one of the predominant complaints was that of generalized itching.

9. *Past History.*—Careful questioning into the past history may often give some information relative to the etiologic basis for the liver disease. One may elicit a history of prolonged alcoholic consumption with dietary deficiency; exposure to hepatotoxins such as chloroform or carbon tetrachloride; recurrent episodes of hepatitis, multiple transfusions, or innoculations.

Physical Findings

Physical findings often suggest the existence of hepatic disease. *Hepatomegaly* is perhaps the most uniform feature. It must be remembered, however, that it is not a necessary requisite for such a diagnosis. In an advanced stage of liver disease the liver may actually be smaller than normal. It is further important to remember that the palpability of the liver is not necessarily evidence of a diseased liver. Other important information is obtained by more detailed examination of the liver itself. For example, the firmness of the liver substance is suggested as a factor of primary importance in the palpability. If at all possible, one should attempt to ascertain the contour of the surface of the liver and determine whether there is actual tenderness of the liver edge. Tenderness may be often misinterpreted due to the fact that the patient may respond by a sudden jerk or gasp as the liver edge slips over the examining finger. This is merely a "shock" reaction rather than an actual tenderness.

Splenomegaly.—The enlargement of the spleen assists materially in differential diagnosis. It is important to distinguish between (1) splenomegaly which develops under observation; (2) enlargement of the spleen, which is present from the onset; and (3) splenomegaly which precedes hepatic enlargement. In general, it may be said that approximately 40 to 50 per cent of patients with chronic liver disease will have palpable spleens. This varies with the individual series reported and, naturally, with the examiners. Spleens many times may be difficult for one examiner to feel, whereas, if a single examiner were to examine all patients, the percentage of splenomegaly might be far higher. Two main factors account for splenic enlargement: (1) portal hypertension and (2) an associated reaction in the pulp or the reticulum of the spleen itself. There may be a reduction of splenic size while patients are receiving treatment. This may not necessarily indicate an improvement but may merely indicate some relief of portal hypertension by coincident development of collateral circulation.

Jaundice.—Chronic liver disease may exist without the objective evidence of jaundice. However, it is invariably present some time during the course of the disease. The intensity of the jaundice is extremely significant and should be evaluated with the following features in view: (1) The immediate onset of a marked intense grade of jaundice implies extensive hepatocellular damage. (2) Fluctuations of bilirubinemia within range of an intense grade of jaundice imply a severe hepatocellular damage and patent bile ducts. At times the objective degree of jaundice will not be compatible with that found in the serum. This is explained by the fact that the pigment may not be cleared from the skin as rapidly as from the serum. It has been observed that the jaundice will clear from the sclerae prior to that from the skin.

Collateral Circulation.—The finding of distended abdominal veins or esophageal varices is generally considered confirmatory evidence of portal hypertension. Five to 10 per cent of patients dying of portal cirrhosis will have a ruptured esophageal varix as the basic cause. Hemorrhoids may be an indication of an anastomatic portocaval shunt. However, the incidence of hemorrhoids in cirrhosis is not as frequent as might be expected. Proctoscopy is suggested to reveal internal hemorrhoids.

Cutaneous Changes.—The findings of spider nevi, palmar erythema, unusual tanning, or prominent venules should suggest the posibility of underlying hepatic disease. During the past year I have observed 2 patients with a peculiar vascular pattern and combined tanning of the face, which seemed to be indicative of chronic hepatic disease. Further investigation revealed that these patients had chronic recurrent hepatitis. Patek has previously described a diffuse vascularity of the skin on the arms.

Multiple Vitamin Deficiencies.—The most prominent of these is night blindness, which is associated with vitamin A deficiency. Vitamin K deficiency is evidenced by hypoprothrombinemia and bleeding tendencies. Vitamin B complex deficiency is manifested by neuritis, cheilitis, and beefy tongue.

Fever.—This has been described as a significant finding in patients with portal cirrhosis. However, it is recommended that all other foci of infection be ruled out before one attributes the fever to the chronic hepatic disease. There may be several factors which may contribute toward a continuous low grade fever or a moderately severe fever: (1) necrosis or autolysis of liver cells; (2) secondary infection in bile channels in the region of necrotic areas; (3) areas of associated pancreatic necrosis; (4)

areas of phlegmonous enteritis with lymphangitic infection of the mesentery; or (5) infected ascites.

One of the most common causes of an associated fever with chronic liver disease is that of pulmonary tuberculosis. In some series there has been an incidence of 10 to 12 per cent.

Blood Changes.—In chronic liver disease the tendency is toward anemia. The anemia of intrahepatic liver disease may be caused either by defective formation of hemoglobin or by fault in the internal metabolism of the antanemic principle. Macrocytic anemia has been described as being indicative of chronic liver disease. There seems to be a definite relationship between the severity and the duration of the liver damage and the incidence of macrocytic anemia. There is nothing particularly characteristic about the leukocytes. Leukopenia may be a feature, especially when chronic splenic changes have developed.

Sedimentation Rate.—This determination is not particularly helpful, and extremely variable findings have been reported. This is explained by the numerous factors which are known to influence the erythrocyte sedimentation rate, most important amongst these being changes in plasma fibrinogen and plasma globulins.

Liver Function Tests.—These tests are constantly being evaluated to determine which of them will prove to be consistently helpful in the diagnosis and the prognosis of liver disease. New tests are being described and older ones are falling by the wayside. It is indeed encouraging that in the past decade those newer tests which have been utilized have seemed to be more helpful in bringing us closer to the ultimate in a series of functions in the detection of hepatic injury. A decade ago one of the first of the flocculation tests was reported and it is still in usage, that of the cephalin-cholesterol. Other flocculation tests which seem helpful at the moment are those of the thymol turbidity and zinc sulfate turbidity. The latter two are more easily performed and more rapidly reported than that of the cephalin-cholesterol flocculation. The zinc turbidity test measures increase in gamma globulin. This has been confirmed by electrophoretic pattern studies of the blood proteins. The flocculation tests seem to be more reliable in patients with acute liver disease or residuals of acute liver disease than in chronic hepatic injury. This is likewise true of the colloidal red dye test, which seems to be a valuable addition in infectious processes directly involving the liver. It has been pointed out that if this test is positive in degenerative or malignant disease of the liver it would appear to indicate a superimposed infectious process, rather than reflect the primary lesion. Several workers have recently pointed out that the thymol turbidity test is primarily a measure of antibody globulin, rather than any alteration or aberration of gamma globulins. The zinc turbidity test measures nonspecific aberrations of gamma globulins. The bromsulfophthalein test continues to be a valuable aid in the diagnosis of chronic liver disease, especially in instances in which superimposed infection does not exist, as, for example, in inactive or compensated portal cirrhosis, hemachromatosis, amyloidosis, and others. The only objection to the use of the bromsulfophthalein test in the past has been the existence of jaundice. It has been suggested by several investigators that in spite of jaundice the bromsulfophthalein test may be of value.

Summarizing the present status of liver function tests for diagnosis or routine screening, it is suggested that the following tests be utilized: thymol turbidity, cephalin-cholesterol flocculation, colloidal red, zinc turbidity, bromsulfophthalein, and, finally, a serum bilirubin determination. Under certain situations it is not feasible to perform this multiple group of tests. In this event, I would suggest that the bromsulfophthalein and the thymol turbidity be utilized.

Additional Diagnostic Aids.—Perhaps the most notable addition to our diagnostic armamentarium has been that of punch needle biopsy. There has been a broad experience in this particular field, and I feel that there is very definite indication for the use of this diagnostic aid. The indications which we have set up are as follows: (1) hepatomegaly of undetermined causation, (2) serial studies of liver pathology for progression and prognosis, (3) vital studies for physiologic changes, and (4) secondary hepatic disease.

Contraindications are (1) liver not palpable 4 cm. or more below costal margin (subcostal method), (2) prothrombin time less than 50 per cent of normal, (3) marked ascites or ileus, (4) acute passive congestion, and (5) bleeding tendencies.

Dangers are (1) hemorrhage, (2) trauma to adjacent structures, and (3) infection of peritoneum.

We have performed more than 500 liver biopsies by the subcostal route and have not had any serious complications. The diagnoses made have been innumerable and include many which have been unexpected prior to the time of the punch biopsy. In the event that there is not an existent hepatomegaly, it is suggested that the intercostal method be utilized or an exploratory laparotomy be performed and a surgical biopsy done.

Another diagnostic aid is that of peritoneoscopy. The procedure has been utilized for combined visualization of the abdominal contents and liver biopsy. There have been several instances in which reports of polycystic disease of the liver have been made and confirmed only through this procedure. We have seen 1 such case.

Summary

It is pointed out that chronic advanced liver disease is not difficult to diagnose. However, minimal or moderate degrees of chronic hepatic impairment sometimes present a confusing picture and test the physician's diagnostic acumen. The diagnosis rests with several factors: (1) that of having a constant alertness to the existence of such a disease entity;

(2) the employment of a careful history, including systemic inventory and a past history interrogation relative to previous liver infections, alcoholic consumption, exposure to hepatic toxins, and nutritional deficiencies; (3) a careful and detailed physical examination; (4) the institution of a liver function profile; the commonly used liver functions were discussed and evaluated; (5) the utilization of additional diagnostic aids such as punch needle biopsy, peritoneoscopy, and, if necessary, surgical exploration and surgical biopsy of the liver. If the above approach is used, chronic liver disease can be diagnosed and the proper therapy instituted in more cases.

Second Annual Scientific Session of the

Wisconsin Chapter of the American Academy of General Practice

Wednesday, November 8

Hotel Loraine, Madison

★

PROGRAM

8:30– 9:30 a. m. Registration—Hotel Loraine

9:30– 9:50 a. m. "Common Errors in Surgery"—K. A. Lemmer, M. D., associate professor of surgery, University of Wisconsin Medical School

10:00–10:20 a. m. "What's New in Diabetes"—E.S. Gordon, M. D., associate professor of medicine, University of Wisconsin Medical School

10:30–10:40 a. m. Welcome Address—W. S. Middleton, M. D., dean, University of Wisconsin Medical School

10:40–11:00 a. m. "Management of Head Injuries"—Henry M. Suckle, M. D., neurosurgeon, Madison

11:10–11:20 a. m. Recess

11:20–11:50 a. m. "Present Status of Cortisone"—Charles Slocumb, M. D., assistant professor of medicine, University of Minnesota Graduate School, Mayo Clinic, Rochester, Minn.

12:00– 1:30 p. m. Luncheon

1:30– 1:50 p. m. "Newer Concepts in Treatment of Pediatric Conditions"—Tnomas Geppert, M. D., pediatrician, Madison

2:00– 2:20 p. m. "What's Happening to General Practice in Wisconsin"—Donald C. Ausman, M. D., Milwaukee

2:30– 2:40 p. m. Recess

2:40– 3:00 p. m. "Infectious Mononucleosis"—John Hirschboeck, M. D., dean, Marquette University School of Medicine

3:10– 3:30 p. m. "Office Gynecology"—Walter J. Reich, M. D., professor of gynecology, Cook County Postgraduate School of Medicine, Chicago

A ten minute discussion will follow each paper.

5:30 p. m. Social Hour—Pompeian Room, Hotel Loraine

6:30 p. m. Banquet—Crystal Ballroom, Hotel Loraine

Guest Speaker: U. R. Bryner, M. D., Salt Lake City, secretary–treasurer, American Academy of General Practice. (Doctor Bryner was the representative of the Section on General Practice of the Commission sent by the American Medical Association to study medical conditions of England and the Continent in the spring of 1950.)

The Surgical Treatment of Ulcerative Colitis*

By JAMES M. SULLIVAN, M. D.
Wood

J. M. SULLIVAN

An assistant professor of surgery at Marquette University School of Medicine, Doctor Sullivan received his medical degree from that institution, later completing a residency in surgery at the State of Wisconsin General Hospital. A diplomate of the American Board of Surgery and a member of the American College of Surgeons, he also maintains a private practice in Milwaukee.

ULCERATIVE colitis, fortunately, is not too common a disease, but each case, unless it be unusually mild, is a difficult therapeutic problem and very few physicians have sufficient experience with it to cope with the many necessary details of management. Cave and Thompson[1] found that in New York City in 1939 there were 59 deaths from ulcerative colitis, as compared with 1,823 deaths from carcinoma of the stomach. Most large teaching hospitals see from 15 to 25 new cases a year, most of which are handled by conservative treatment. As this paper is primarily concerned with the surgical management of the disease, I shall not touch on the medical treatment.

Lahey[2] states that 59 per cent of the cases which he and his associates see in Boston can be controlled by dietary management, and the rest, or 41 per cent, come to surgery. Strauss[3] in commenting on the same problem divides his cases into two types: no. 1, the mild or superficial type, in which only the mucosa is involved; and no. 2, the severe type, in which all coats of the bowel are involved. In the mild type medical treatment usually suffices for management, and the severe types eventually come to surgery. The reason that surgical procedures are not used more often in ulcerative colitis is the fact that up to a year ago the only treatment that could be offered was an ileostomy followed in about one-third of the cases by a colectomy, and the difficulties of taking care of an ileostomy were such that it was abhorrent to most patients and their medical attendants. However, in those clinics where an ileostomy is carefully done and carefully cared for with a Koenig Rutzen bag, more and more patients are coming to surgery. In Wangensteen's[4] group during the past 16 months, 23 new cases of ulcerative colitis came into the hospital and in only 7 of these the patients did not come to surgery. They also found, in reviewing their statistics for the past 10 years, that of the 57 patients that were treated medically they had a 28 per cent mortality and of the 25 patients treated surgically they had only an 8 per cent mortality.

The indications for ileostomy are pretty well agreed upon by most writers.[1-5] Dennis[4] gives his indications as follows:

A. Emergency:
   1. Uncontrollable hemorrhage
   2. Fulminating disease
   3. Impending perforation
   4. Obstruction

B. Elective:
   1. Colitis resisting medical treatment
   2. Segmental ulcerative colitis
   3. Very early ulcerative colitis
   4. Polyposis with possible malignancy

Cave and Thompson[1] do not feel that uncontrollable hemorrhage is an indication for an ileostomy, but insist that they can control hemorrhage in all cases by transfusions and vitamin K therapy until the emergency is over, and the ileostomy can then be done as an elective procedure. All the authors in the previous references except Strauss[3] believe that in most cases segmental colitis can be handled by resection of the involved segment, but no one cites more than 2 or 3 cases. Strauss feels that one can never tell when the segmental colitis may spread to other parts of the bowel, and we have had one personal experience to substantiate this view. Dennis[4] and Lahey[2] both feel that if more of the patients in the early stages of ulcerative colitis were submitted to surgical procedures more cures would be obtained and the ileostomies could be hooked up again.

The dangerous part of doing an ileostomy is well illustrated by table 1, which is taken from Cave and Thompson.[1] Their total mortality for 34 cases was 23 per cent, with the emergency ileostomies producing a 50 per cent mortality and the elective ileostomies producing a 9 per cent mortality. It is, therefore, easily seen why an ileostomy should be done as an elective procedure if the patient can be possibly brought out of his acute phase of the disease before operation is performed or if an ileostomy can be done a little earlier, before an acute fulminating phase of the disease develops.

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are a result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

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TABLE 1.—*Deaths from Ileostomy*

Reprint from Cave and Thompson[1]

Type of Surgery	Number of Cases	Deaths, No.	Mortality, %
Ileostomies	34	8	23
Emergency ileostomies	12	6	50
Elective ileostomies	22	2	9

In many cases the improvement after ileostomy is sufficiently satisfactory so that colectomy will not have to be considered. The indications for colectomy are as follows: (1) persistence of profuse flow, (2) presence of polyps or carcinoma, (3) profuse bleeding, or (4) recurrence of symptoms after a period of quiescence. The colectomy should not be done until three months or more have elapsed, and it can be done in one stage, leaving the rectum in.

Strauss[3] insists that the ileum should never be reconnected back up to the rectum. Lahey[2] and Garlock[5] each report 5 cases in which they have been reconnected, and Dennis[4] and his group have 6 cases in which an ileoproctostomy was done. All these men feel that if the patients with ulcerative colitis were treated by surgical procedures earlier, there would be many more patients that could be so treated. We have had no personal experience with this procedure.

The reports of Dennis and his co-workers[6] on their experiences with vagotomy in the treatment of ulcerative colitis prompted us to try this procedure in 7 cases to see if we could duplicate their results and to try to estimate its efficiency.

Table 2 gives the pertinent data in these 7 cases. Three of the patients had ileostomy performed before they were considered for further therapy. All 3 were doing very poorly with their ileostomies. In cases 2 and 4, a vagotomy was performed within a month after the ileostomy. Results were immediate and dramatic in both cases. The patient in case 3 progressed fairly well after the ileostomy but did not gain weight, and the ileostomy movements were fairly frequent. Following vagotomy, he too showed dramatic improvement.

The patient in case 1 afforded our most dramatic response. He had been undergoing medical treatment for two months in the hospital and steadily was losing ground. His disease was also fairly early, having existed for only eight months. Following vagotomy this patient made a dramatic and prompt improvement and was discharged from the hospital one week postoperatively. One month later, he had gained 15 pounds, was having only one or two stools daily, and proctoscopic examination of

TABLE 2

	Age	Length of Disease	Pre-entry Stools per Day	Medical Treatment in Hospital	Preoperative Stools	Operation	Postoperative Course
1. RK	21	8 mo.	18–20	Sulfasuxidine, proteins, and blood	2–10	2nd month after admission Vagotomy	Discharged from hospital 1 week post-operatively 1 month later 1-2 stools Gained 15 lbs.
2. RR	28	16 mo. Lost 50 lbs.	24 stools per day	Sulfasuxidine and sulfadiazine, penicillin, blood and proteins	20	9–21–48 Ileostomy some improvement. 10–6–48 Vagotomy	11–6–48, 1 to 2 ileostomy movements Improved immediately
3. EG	25	3 weeks Lost 60 lbs.	Almost continuous bloody diarrhea and distention	Antibiotics, sulfa, blood, Wangansteen	15 per day	Ileostomy 7–6–48 Vagotomy 10–27–48	Discharged Dec. 12, 1948 3 per day from ileostomy. 2 times weekly from rectum
4. CG	34	3 years Wt. loss 50 lbs.	April 1948 6 stools daily. Continued to increase esp. between 9 PM and 1 AM—movement every half hour then	Blood, high protein and high carbohydrate diet, amigen intravenous daily and duracillin	Continuous	Ileostomy 9–16–48 Vagotomy 10–1–48	Discharged Jan. 29, 1949 3 ileostomy movements. Continues to gain weight.
5. SL	41	4 years	1944—10–12 1946— 1947—3–5 1948—20	Sulfa-thalidine and sulfasuxidine, duracillin, I.V. feedings	20 per day	Vagotomy 3 weeks after admission 12–23–48 Ileostomy 1–7–49 Post ileostomy 1949 Colectomy 8–3–49	No decrease in stools Constant drainage 5–12 per day Post colectomy 2 per day
6. BH	31	3 years	5 stools per day	Penicillin, sulfa thalidine, whole blood, high protein diet, viodenum	5–7 per day	Vagotomy Transthoracic 8–17–49	4 per day 8–27–49
7. C St.G	38	12 years	4–7 per day	Penicillin Parenteral fluids	4–7 per day	Cecostomy 1944 Abdominal vagotomy 3–25–49	1–2 per day

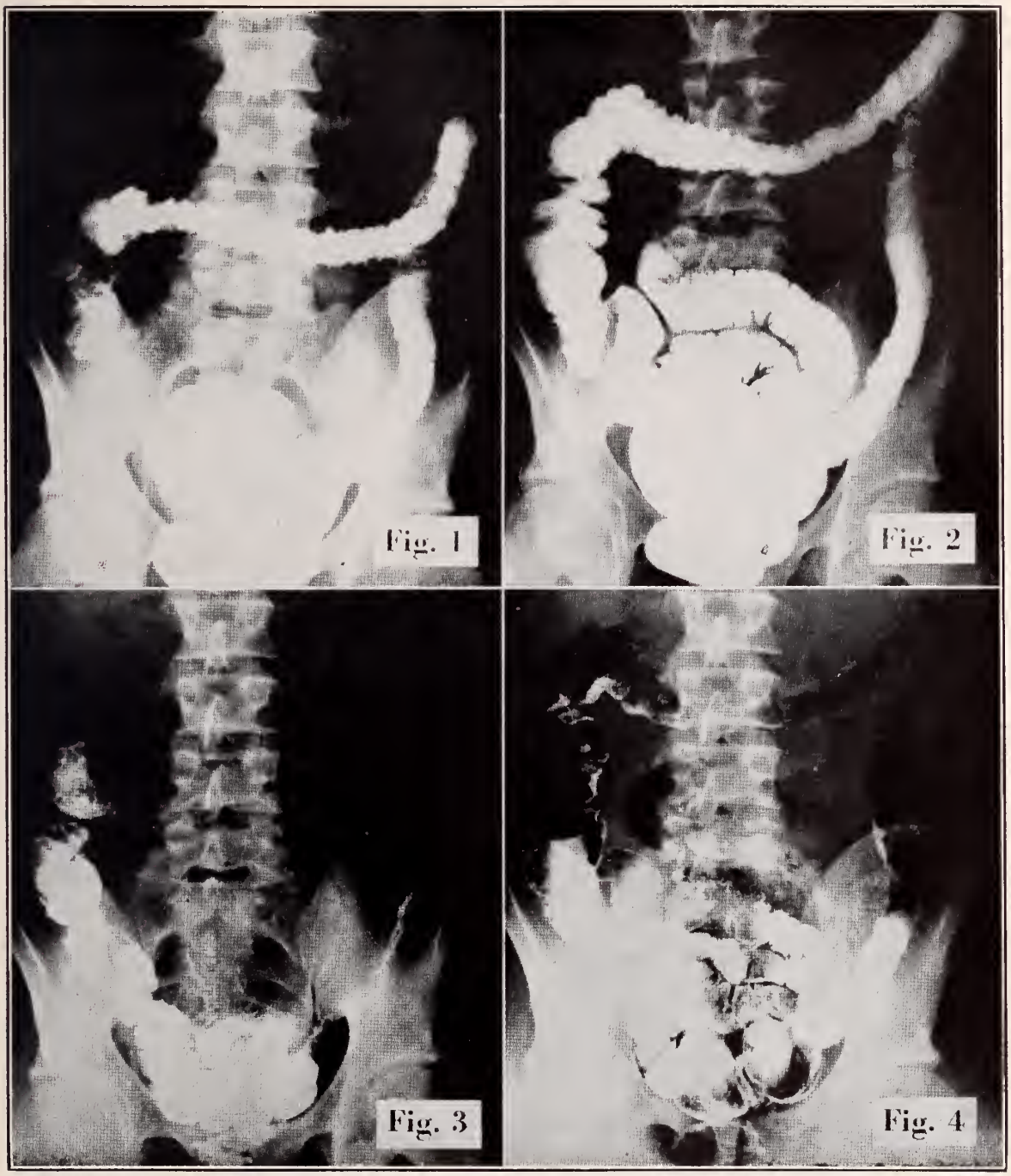

Fig. 1 (case 1).—Film was taken on Nov. 17, 1948, in preoperative barium enema study. Patient's history of ulcerative colitis was of eight months' duration, during which the disease failed to respond to intensive medical treatment. Fig. 2 (case 1).—Film was taken on March 10, 1949, in postoperative barium study three months after vagotomy. Number of daily movements had been markedly reduced at this time, and patient's course was progressively favorable. Fig. 3 (case 1).—Emptying film was taken on March 10, 1949, following barium enema study three months subsequent to vagotomy. Patient was discharged from hospital one week postoperatively, displayed rapid improvement and weight gain. Fig. 4 (case 1).—Postoperative air contrast study, part of series taken on March 10, 1949, three months after vagotomy, reveals multiple pseudopolyps still present throughout entire colon, but apparently smaller than on previous examination. (Reprinted from Marquette Medical Review[7]).

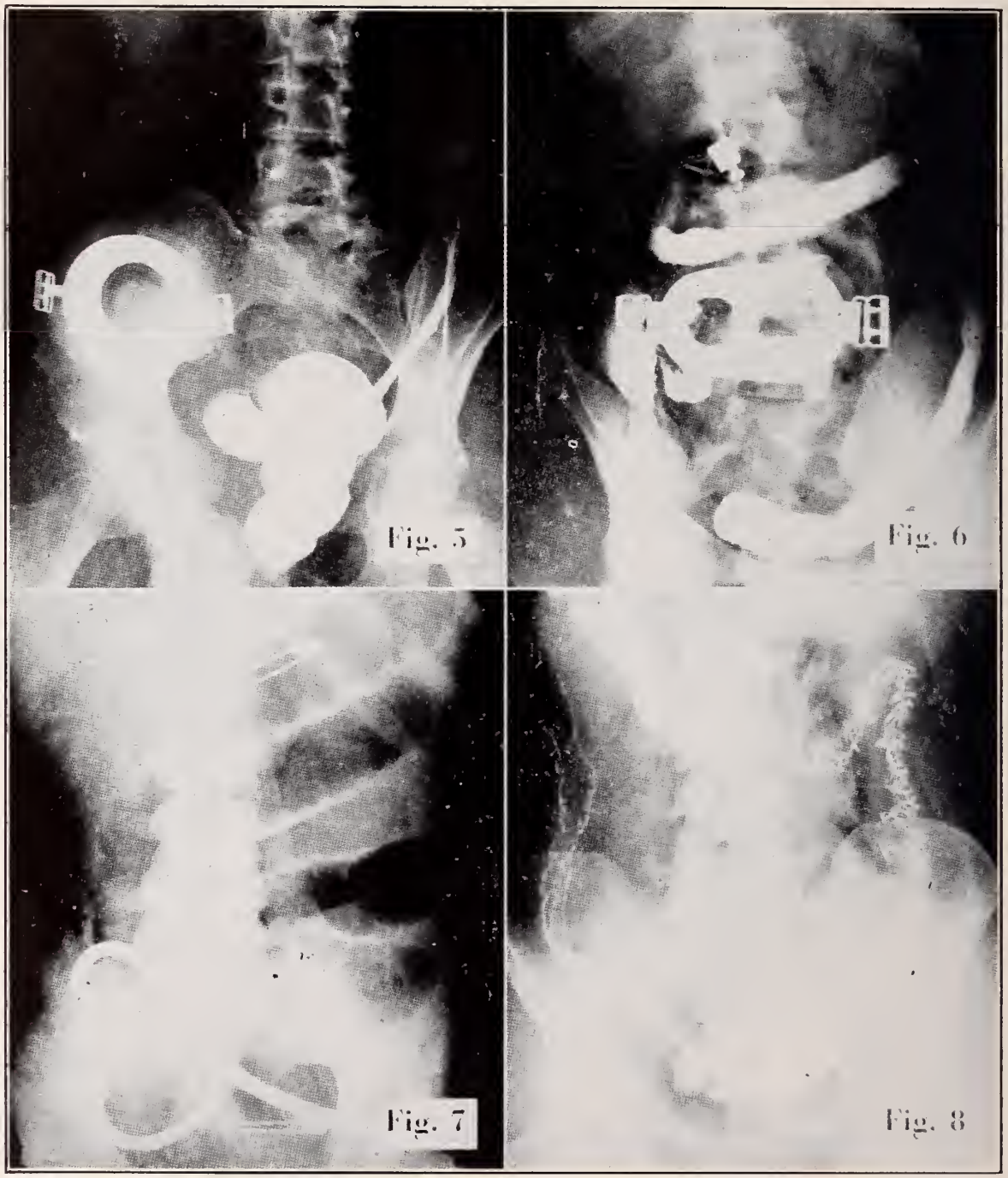

Fig. 5 (case 2).—X-ray film taken on March 10, 1949, five months subsequent to vagotomy, illustrates amount of fibrosis in the descending colon. Film is one of postoperative barium enema series to check progress. Fig. 6 (case 3).—Barium enema study made on March 10, 1949, four and one-half months postoperatively, indicates amount of spasm in transverse and descending colon. Condition was too precarious prior to surgery to permit study. Irregular mucosal pattern is seen. Fig. 7 (case 4).—This film taken on day of surgery, Oct. 1, 1948, prior to vagotomy, shows small bowel obstruction with typical stepladder appearance. Degree of distention met with in acute case of ulcerative colitis is well demonstrated. Fig. 8 (case 5).—Preoperative barium enema study on June 18, 1945, reveals gross enlargement of entire large bowel. Film was taken three and one-half years prior to vagotomy. Narrowing of lumen and moth-eaten appearance of mucosa can be discerned without difficulty (Reprinted from Marquette Medical Review[7]).

his lower rectum showed very little residual evidence of his disease.

Our poorest result was the patient in case 5, who had had his disease four years. On admission into this hospital, he was in such a precarious state that he received only three weeks of medical treatment before being referred for surgical treatment, as a lethal outcome was imminent. An emergency vagotomy was performed. For five days postoperatively, he responded well and his stools decreased to five per day. Oral feedings were started and his stools increased to 15 daily. An ileostomy then was done, and since that time improvement has been slow, but progressive. Because of the presence of many pseudopolyps and slow improvement, colectomy was decided on; it was performed August 3, 1949.

Figure 1 is an x-ray taken of the patient in case 1 on Nov. 17, 1948, and shows a definite picture of ulcerative colitis. The lumen of the bowel is narrowed and there is a moth-eaten appearance of the mucosa.

Figure 2 is an x-ray picture of the same patient, taken three months postoperatively and still shows narrowing of the large bowel but some improvement has occurred; the haustral markings are more prominent and the lumen is wider.

Figure 3 shows an evacuation picture in the same case, and again definite improvement is noted.

Postoperative barium studies in all the other cases show similar improvement, and even the pseudopolyps present in case 1 in the initial picture appeared smaller on follow-up x-ray studies.

Proctoscopic examination was done in all cases and showed typical changes of severe ulcerative colitis, namely, punched-out ulcer, granular changes, and extreme congestion. Postoperatively all patients have shown improvement. The patients in cases 1 and 2 are practically normal. The patient in case 3 is improved, but still has some changes present. Those in cases 4, 6, and 7 are still too early to evaluate.

Figure 7 is an x-ray picture of the patient in case 4 which was taken preoperatively and illustrates very forcibly the amount of small bowel obstruction, and the typical stepladder appearance that is frequently met with in cases of acute ulcerative colitis.

It is very difficult to evaluate the treatment in our 7 cases of ulcerative colitis by vagotomy, because the disease itself is characterized by remissions and exacerbations, and to date insufficient time has elapsed since operation to determine the final results.

However, we are very favorably impressed by our results in 6 cases, and even in the seventh case the improvement has continued. It is hoped that improvement will persist in all of these cases and that colectomy will be avoided.

As to the ideal time for vagotomy, it would seem from our limited experience that if the course of the disease may be stopped prior to loss of muscular tone and, above all, prior to fibrosis, the better and more striking the results. At any rate, vagotomy seems worthy of further trial in the treatment of this crippling disease.

Conclusions

1. A considerable number of patients with ulcerative colitis will require surgical treatment.

2. The time-honored treatment of ileostomy followed by colectomy will satisfactorily control the disease, but this type of treatment requires two major operations and meticulous attention to detail for a successful outcome.

3. Very few cases have been reported in which bowel continuity was re-established by ileoproctostomy because operation was not performed until irreversible changes in the bowels had been produced.

4. Vagotomy for ulcerative colitis, in a series of 7 cases, showed immediate and dramatic improvement in 6 and slower improvement in 1.

5. We feel that this new surgical approach to the treatment of ulcerative colitis offers possibilities and further trial is indicated.

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AMERICAN COLLEGE OF SURGEONS TO HOLD CLINICAL CONGRESS IN BOSTON

The thirty-sixth clinical congress of the American College of Surgeons will be held in Boston, October 23–27, with headquarters at the Hotel Statler.

Every effort will be made to have the meeting contribute its share to promoting the medical aspects of civilian defense and of care of the military forces. Twenty-five hospitals in the vicinity will conduct clinics for the visiting surgeons every morning and afternoon. Surgical procedures at Massachusetts General Hospital will be televised in color to Mechanics Hall every morning except Monday and every afternoon except Friday.

Anesthesia and Analgesia for the Obstetric Patient From the Viewpoint of an Anesthesiologist*

By JAMES W. BOOKHAMER, M. D.
Milwaukee

J. W. BOOKHAMER

A diplomate of the American Board of Anesthesiology, Doctor Bookhamer received his medical degree from Marquette University School of Medicine in 1940. After his internship he spent two years of residency in anesthesia at the University of Iowa, returning there for six months as research assistant following four years of service in the United States Army. For the past four years he has been staff anesthesiologist at Milwaukee Hospital.

THE discussion of anesthesia and analgesia for the obstetric patient from the viewpoint of an anesthesiologist should be no different than that of an obstetrician, for together they are a team, and they must practice as such.

For centuries prior to the development of modern anesthesia, attempts were made to relieve the pain of childbirth. In 1818 Benjamin Rush expressed the hope that a medicine would be discovered which "would suspend sensibility altogether and leave irritability or the power of motion unimpaired and thereby destroy labor pains altogether." To Sir James Simpson belongs the credit for the introduction of modern anesthesia in obstetric practice. He first used ether in January 1847, when he performed an internal podalic version for a prolapsed cord. The popularity of anesthesia in obstetrics gained impetus when John Snow administered chloroform to Queen Victoria in 1853.

The developments in obstetric anesthesia have always been slow to follow those in surgery. The problem is receiving more attention and study than ever before, and rightly so. The goal in obstetric anesthesia should be to safely provide for the mother and infant during labor and delivery the comparable freedom from pain now enjoyed by the patient undergoing surgical procedures. This goal is greatly complicated by the two lives which must be considered, for what affects the one, generally speaking, also affects the other.

Analgesia may be accomplished by the use of small amounts of any of the agents used for anesthesia. However, this usually involves the problem of trained personnel for administration, and today this is a problem in itself. Also, intermittent analgesia produces a prolongation of the labor in some cases. The use of oral and parenteral drugs which produce relief from pain also produce respiratory depression. This depression may not manifest itself in the mother, who is stimulated by pain, but it is too often present in the newborn infant. Morphine, which depresses respiratory rate, and demerol, which depresses respiratory depth, should not be used per routine orders, as should not the barbiturates. Waters has demonstrated that 4.5 grains of barbiturate lowers respiratory exchange by 23 per cent. It has been demonstrated experimentally by Wolff, Hardy, and Goodell that pain threshold is increased 65 per cent with 1/6 grain of morphine, 75 per cent with ¼ grain of morphine, and 90 per cent with ½ grain of morphine. Clinically, Beecher states that relief from pain in wounded men in the last war was obtained with ⅛ grain of morphine and that doubling and redoubling the dosage gave no further clinical relief of pain. These findings should indicate that the dose of pain-relieving drugs should be lowered from what is ordinarily given, for the less depressing drugs given the mother, the less the infant receives. The use of scopolamine not only produces a degree of amnesia, but counteracts to some degree the depressing effect of these drugs.

The onset of labor usually causes a cessation of active gastric digestive processes, and food in the stomach at that time, or any subsequently added, usually remains there. Morphine and allied drugs are known to produce a constriction of the pylorus, further preventing passage of stomach contents into the duodenum. Now orally administered barbiturates are absorbed from the small intestine, only 10 to 20 per cent being absorbed from the gastric mucosa. This helps explain the unpredictable results the obstetrician obtains with oral medication with barbiturates. Further, the mother in labor often regurgitates, and the nurse, assuming the medication has been thusly lost, repeats the routine order. In the light of this, would it not be better to order 1 to 3 grains of barbiturate intramuscularly and observe a constant predictable effect? This dose compares favorably with the oral dose of 4½ to 6 grains in the obstetric patient.

There are many agents and many procedures for obstetric analgesia and anesthesia, but not many are applicable to the busy physician, either the general practitioner or the obstetrician. Hypnosis is again receiving some interest, and it shall find its place in certain cases as have many other proce-

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

dures. Recently, remarkable results were obtained by Volpitto, using intravenous administration of demerol. But all these procedures are painstaking and require special training and extra time with a mother in labor.

During the course of labor, one should continually bear in mind the degree and rate of progress and evidence of exhaustion in either the mother or the fetus. Dehydration, restlessness, tachycardia, and alteration in uterine contractions are evidence of maternal exhaustion and should not be explained away as premedication. Change in fetal heart rate and fetal activity may mean fetal exhaustion, and its treatment depends on the judicious use of hydration, oxygen, dextrose, proper sedation, etc., rather than by forced labor. Few episodes in medicine are as dramatic as the correction of fetal hypoxia by the continuous administration of oxygen to the mother.

In discussing drugs used for analgesia and anesthesia at the termination of the second stage of labor, it must be noted that all require trained personnel for administration. To quickly run through some of them, ethyl chloride is mentioned only to condemn it. It is, in itself, too toxic and too dangerous in even the best of hands. Pentothal sodium is a marked depressant and its margin of safety is small. A blood level in the mother sufficient to give her anesthesia is much too high a blood level in the infant. Barbiturates are hypnotics and have no analgesic or anesthetic properties. They do not block nerve impulse as do our other true anesthetics. Pentothal produces its effect by interfering with the oxygenase system in the brain, and in many respects its effect resembles the state of hypoglycemia. Ethylene to be effective should be used in a semiclosed system, which means some escape into the room. This introduces the hazard of explosion, and, as it is only 10 per cent more potent than nitrous oxide, with no other superior qualities, I see little need to use it.

Nitrous oxide in the fairly well sedated mother and in 80 per cent concentration is an excellent analgesic. It should never be used in concentrations greater than 80 per cent, for with less than 20 per cent oxygen, fetal hypoxia will occur. This may mean insufficient anesthesia with a resulting perineal nystagmus during actual delivery, but this can be corrected by the addition of a local agent, or by the addition of a small amount of ether. To repeat, nitrous oxide should never be pushed, and it should never be used with less than 20 per cent oxygen, regardless of the fact that there may be no cyanosis with as high as 90 per cent nitrous oxide. Cyanosis indicates reduced hemoglobin content, not arterial oxygen saturation; in fact, in patients with less than 6.5 Gm. of hemoglobin it is impossible to produce cyanosis.

Cyclopropane is extensively used for obstetric patients, and in experienced hands is an excellent agent. However, the use of large doses of analgesic drugs, followed by cyclopropane may be depressant to the infant. Thus, in a surgical patient who receives ¼ grain of morphine followed by cyclopropane, there are quite frequent apneas during induction before the patient is completely anesthetized. They may persist for as long as a minute before the patient resumes breathing and may recur after several breaths. It is an infrequent occurrence with ⅛ grain of morphine and even with 1/6 grain. Is it not quite likely that the fetal depression observed following cyclopropane anesthesia is a result of the heavier medication? This problem does not exist in cesarean sections, for these mothers receive only atropine or scopolamine, nothing else, and little infant depression is seen in these cases from the use of cyclopropane.

Chloroform is an excellent agent in experienced hands. Preferably, it should be used with oxygen to aid in the prevention of liver damage, and it is best used intermittently for late second stage analgesia. In the hands of the neophyte it should not be used. One should pay constant attention to the pulse and, at the first sign of irregularity, discard it for other agents. Chloroform sensitizes the heart and causes cardiac arrest before cessation of respiration. It is thought that many deaths caused by chloroform are due to sudden high concentration of the agent, as is likely to occur during its administration as a mother takes a sudden deep gasp with a pain. One must anticipate such actions in using chloroform in obstetrics. Vinethene is replacing chloroform in many localities, it being somewhat less hazardous.

Light ether anesthesia has stood the test of years. It is the safest in the hands of the less experienced and certainly the agent with which one should first become familiar.

All of these agents are depressants to both mother and infant. One does, however, have approximately 10 minutes before the fetal blood levels of these agents reaches the maternal blood levels. This 10 minutes is maximum time, and the period is shortened by many factors. In general, the shorter period of time from the beginning of anesthesia until the clamping of the cord, the less depression of the infant.

Let us turn for a few minutes to other means of anesthesia, namely, local infiltration and regional blocks. Local infiltration is an excellent means of delivery with episiotomy, but offers no relief of labor pain. Pudendal nerve block accomplishes the same thing without distorting the tissues with the local agent. It, too, offers no relief of labor pain. Caudal anesthesia, single, intermittent, or continuous, is a good technic, the background of which requires special training. The abuse which has been heaped upon caudal anesthesia is not due to the technic or the agents used, but is due to insufficient knowledge of the technician as regards chemistry and pharmacology of the agent and anatomy and physiology of the caudal canal and associated structures. In other words, one should not use caudal without sufficient knowledge of these basic science

applications of this technic, which is a relatively simple one. What I have said applies equally to low spinal, or saddle block, as it is popularly called, and to the newer epidural blocks.

Short postgraduate courses are available in these technics, and it behooves anyone desiring to use them to thusly acquire the knowledge in an efficient and rapid manner. The technic of anesthesia is much simpler to learn than the technic of internal podalic version, breech extraction, etc., but the theoretic background in anesthesia is as profound as in obstetrics. Any physician attempting special technics in either obstetrics or anesthesia without the necessary background and training is doing his patient an injustice.

"Control of Pain in Childbirth" by Lull and Hingson is an excellent book on this subject. Snyder's "Obstetrical Analgesia and Anesthesia" is a comprehensive review of the scientific approach and the new facts regarding anesthesia in obstetrics. All obstetricians and anesthetists should read it.

I have but briefly scratched the surface of anesthesia and analgesia for the obstetric patient. The very fact that there are so numerous agents and technics should indicate that the ideal has not been found. And should such an agent be found—as was insulin for diabetes—it should be borne in mind that, as with insulin, the dosage is an individual problem and routine orders will only increase maternal and fetal mortality.

AMERICAN COLLEGE OF CHEST PHYSICIANS SPONSORS POSTGRADUATE COURSES; OFFERS PRIZE IN ESSAY CONTEST

The Council on Postgraduate Medical Education of the American College of Chest Physicians announces that it will sponsor two postgraduate courses in recent advances in diseases of the chest. The first postgraduate course will be held at the St. Clair Hotel, Chicago, October 16–20. The second will be held at the Hotel New Yorker, New York, November 13–18.

Tuition for each course is $50.00. Applications will be accepted in the order in which they are received as registration will be limited.

Address all inquiries and applications to the Council on Postgraduate Medical Education, 500 North Dearborn Street, Chicago 10, Illinois.

The Board of Regents of the American College of Chest Physicians offers a cash prize award of $250 to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease. The prize is open to contestants of other countries as well as those residing in the United States. The winning contribution will be selected by a board of impartial judges and the award, together with a certificate of merit, will be made at the forthcoming annual meeting of the College to be held in Atlantic City, N. J., June 7–10, 1951.

The college reserves the right to invite the winner to present his contribution at the annual meeting and to publish the essay in its official publication, *Diseases of the Chest*. Contestants are advised to study the format of *Diseases of the Chest* as to the length, form, and arrangement of illustrations to guide them in the preparation of the manuscript.

The following conditions must be observed: (1) five copies of the manuscript, typewritten in English should be submitted to the Executive Office of the College, 500 North Dearborn Street, Chicago 10, Illinois, not later than April 1, 1951. (2) The only means of identification of the author or authors shall be a motto or other device on the title page and a sealed envelope, bearing the same motto or device on the outside, enclosing the name of the author or authors.

Neoplasms of the Genitourinary System in Children*

By N. W. BOURNE, M. D.
Milwaukee

N. W. BOURNE

Doctor Bourne, a graduate of the University of Michigan Medical School, has served as the chief of the urologic section of Milwaukee Children's Hospital for the past sixteen years. Following internship at the University Hospital in Ann Arbor, Mich., he was on the surgical staff of that institution for three years before moving to Milwaukee. He has been certified by the American Board of Urology and is a member of the American Urological Association.

FOR all practical purposes, malignant growths of the genitourinary system in children affect mainly the kidney, and, in the boy, the testicle and the prostate gland. The question of malignant tumors in the epididymis, vas, scrotum, penis, urethra, bladder, and ureter in the child can be dismissed in a very few words. Malignant disease of the epididymis and vas and spermatic cord is rare in the adult and practically non-existent in the child. Scrotal cancer in seen rarely in the adult and never in the child. Malignant growths of the penis, urethra, bladder, and ureter in children are also diseases which one must consider but probably will never see. When malignant disease does occur in the child's bladder, sarcoma is more apt to occur than carcinoma. There is no record of any such malignant disease in the urologic section of the Milwaukee Children's Hospital.

Malignant Tumor of the Kidney

The most common malignant growth of the genitourinary tract in children is that of the kidney. This is the malignant embryonal tumor of the kidney, or Wilms' tumor, which is rare in adults but is frequently found in children. The symptoms of renal tumor of childhood are different from those of the adult type of tumor. Hematuria, for example, is relatively rarely a complaint in connection with the Wilms type of tumor. Also, in the child, tumor of the abdomen and pain and intestinal symptoms are often the first symptoms which attract the attention of the patient's family. Tumor is the initial symptom in over 60 per cent of the cases of Wilms' tumor, and is associated with pain, weakness, vomiting, or hematuria in over 90 per cent of the cases. Hinman states that in children under 6 all other tumors of the upper part of the abdomen are so rare that such a tumor may be called a renal tumor (malignant, hydronephrotic, or polycystic) with small chance of error. The splenic enlargements of infancy are distinguished by the blood picture.

The diagnosis is made by excretory urograms or retrograde pyelograms. We were able to transilluminate a large cystic kidney by the use of a small flashlight in an infant's rectum in 1 case in which we could not obtain diagnostic urograms.

The accepted treatment of this tumor is surgical removal of the kidney, usually preceded by deep x-ray therapy and often followed by such treatment. Theoretically, there are several possible methods of treatment. These tumors are known to be radiosensitive, and some authors have advised radiation without surgical treatment. This is not an accepted view today. Surgical treatment may be used without radiation. Preoperative radiation can be given and then operative procedures and postoperative radiation may be used. Operation followed by radiation may also be used. We have used preoperative radiation in most of the cases, especially when the tumor is large and seems to be fixed to the neighboring structures. Radiation often shrinks the tumor so it is more easily handled by surgical treatment. Some surgeons suggest that if the tumor is operable it should be removed very soon, to prevent metastases if possible. The radiologists reply that preoperative radiation may devitalize the tumor cells so that the danger of metastasis during operative procedures is lessened. Postoperative radiation has been used in cases in which the tumor has been found to be extensive and in which the danger of local extension has been present.

The prognosis of these tumors is serious. Some authors, such as Alcock, point out that the tumor may present itself again as late as 15 or 20 years after the operation. In 1949 Gahagan and Yearwood found only 33 five year survivals in some 553 cases in the literature. In the same group, Nesbit reported 6 five year survivals in 16 cases in which the patients were treated at the University of Michigan Hospital. In our small series of cases, about a third of the patients on whom operations were performed have survived more than three years. These tumors are rapidly growing, and, if the patient has an immediate survival of a year, the prognosis is usually good for many years.

I should like to present the histories of a few cases of Wilms' tumor in children.

The first case is that of J. D., male, aged 18 months, who entered Milwaukee Children's Hospital on Feb. 18, 1947, with a history of an abdominal

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

enlargement of four or five months' duration. No history of constipation, vomiting, or bleeding in either the bowel movements or the urine was obtained. This child had been tired and slightly listless but otherwise quite well. Examination showed a large mass, very firm and not tender, which filled the right side of the abdomen to beyond the midline and extended high under the diaphragm and down into the right lower quadrant. The mass was fixed and quite firmly adherent to the posterior abdominal walls. Large dilated superficial veins were seen over the right side of the abdomen. No enlarged lymph glands were palpable. Urinalysis showed no albumin or sugar, and the urinary sediment was normal. The blood cell count showed a mild anemia. An excretory urogram showed normal function of the left kidney and normal shape of the left renal pelvis, while the right renal pelvis and calices were markedly deformed and displaced in a superior direction. A large soft tissue mass completely filled the right side of the abdomen. X-ray examination of the chest showed no metastases. A diagnosis of Wilms' tumor on the right side was made. Because of the size and fixation of the tumor, preoperative radiation was given this child. Nine x-ray treatments of 195 roentgens each were given to the anterior, lateral, and posterior right kidney area, for a total of 1,755 roentgens. The x-ray treatments were completed on March 12, 1947. About a month later, on April 10, 1947, right nephrectomy was done. By this time the renal mass had decreased in size and had become movable, and, therefore, surgical treatment was undertaken. In separating the tumor mass from the peritoneum, it was found that the peritoneum was adherent in the region of the cecum and the cecum and the appendix were exposed through a rent in the peritoneum. The peritoneum was dissected off from the tumor in this region, and no discernible injury to either the cecum or the intestine was seen.

The child stood the operation very well and had a smooth convalescence. The report of the pathologist was that of Wilms' tumor of the right kidney. Because of the extensive size of this tumor, postoperative radiation was also given this child.

In spite of all the radiation and surgical procedures, widespread metastases developed, and the child expired on Nov. 13, 1947, seven months after his nephrectomy. An autopsy reported the following metastatic areas: arm, skin, liver, lungs, vertebrae, skull, ribs, and pancreas.

Another case is that of M. W., a girl aged 2 years, who entered the hospital on Dec. 5, 1938, with nausea, vomiting, and pain in the right side of the abdomen. The child had been taken ill the previous night with abdominal pain and vomiting. This continued whenever food or fluids were offered. Examination showed a large mass in the right side of the abdomen, movable, and very tender on palpation. The rectal examination was negative. The urine showed albumin and 10 white blood cells, and a few red blood cells. The blood nonprotein nitrogen value was 30. Excretory urogram showed a large mass in the right side with no function of the right kidney, and a normal left pyelogram. Cystoscopy revealed a normal bladder and ureteral orifices. The retrograde right pyelogram showed pronounced displacement of the right ureter and a markedly distorted right pelvis. A diagnosis of Wilms' tumor was made. Roentgen therapy was given and the mass reduced in size 50 per cent. A month later transperitoneal nephrectomy was done by Dr. Charles Fidler. The pathologist's report on the tumor of the right kidney was "mixed cell sarcoma of the kidney." This child has been well for over 10 years and was examined in my office a month ago.

A third case was that of a small girl, aged 2 years, J. M., who entered the hospital on Oct. 5, 1944. This child had experienced hematuria, dysuria, and frequency for the previous five days. No abdominal mass was palpable, and there were no abnormal findings except for the hematuria. Cystoscopy was done and the bleeding was seen coming from the right ureteral orifice. Retrograde studies were done and the left pyelogram was found to be normal, while there was a large filling defect in the upper pole of the right kidney. The child was bleeding freely from her kidney, and an immediate operation was done. A large cystic tumor of the upper pole of the right kidney was found, and the right kidney was removed. Later, postoperative x-ray treatments were given. The pathologist called this also a Wilms tumor. This girl has had no evidence of metastasis and is now well nearly five years after her operation.

Malignant disease of the testicle does occur in infancy and childhood, but it is rare. Most of the textbooks tell us that there is more of a tendency for a malignant growth to develop in a cryptorchid than in a testicle in its normal site. This theory has recently been contested, but it is still worthy of consideration. The pathology of the malignant testical is either of the homologous type, such as the seminoma, or of the mesoblastic type or the adrenal rests; or of the heteroblastic type, such as the teratoma, which may show few malignant changes, or be very malignant.

The treatment of cancer of the testicle is surgical removal of the testicle and cord and abdominal dissection of the retroperitoneal glands, or orchiectomy followed by radiation of the abdomen.

Malignancy of the Prostate in Children

Sarcoma of the prostate gland is chiefly a disease of children. Bittoni found that in 34 per cent of reported cases the disease occurred in children under 10 years of age. It is a rare disease, however. In 1928 Powell reported 2 of his own and found 91 others in the literature. Almost 40 per cent of these 93 were in children under 10 years of age. The pathology of the lesion shows many varieties. Lymphosarcoma, spindle cell, myxosarcoma, adenosarcoma, angiosarcoma, and many others are described. They arise from the upper part of the prostate and grow with great rapidity and attain great size. The base of the bladder is pushed up and forward and, the seminal vesicles are involved early. From the diagnostic standpoint, sarcoma of the prostate usually causes retentive symptoms. It is usually large and soft and may even feel fluctuant, but it may also be hard and nodular. It grows rapidly and causes early cachexia. The treatment of sarcoma of the prostate is not satisfactory. Surgical procedures have been found wanting in the treatment of this disease, and either x-ray or radium seems to be of some help, but none of the authors have been optimistic about the treatment of this disease.

Miscellaneous Neoplasms in Infancy and Childhood*

BY A. A. SCHAEFER, M. D.
Milwaukee

A. A. SCHAEFER

An assistant clinical professor of surgery at Marquette University School of Medicine, Doctor Schaefer received his M.D. degree from Harvard Medical School in 1928. Following internship at Columbia and Milwaukee Children's hospitals, Milwaukee, he served a residency in surgery at Columbia Hospital during 1930 and 1931.

CANCER in infancy and childhood is a relatively new study which has previously been badly neglected. A few reports are scattered through the literature, from Duzan's collection of 281 cases in 1876 to Helmholz's 750 cases seen at the Mayo Clinic up to 1931.

In 1939 Dargeon collected 1,538 cases from the world literature and stimulated others[10] to study the subject. He pointed out that many cancers of childhood are curable and that the prevalent hopeless attitude of many physicians was not justified.

Malignancy in this age group is becoming relatively more important in the mortality tables. Dublin, of the Metropolitan Life Insurance Company, reports that it is now the second ranking cause of death from the ages 1 to 14 years and that in 1930 it did not even rank among the first 10 causes of death. This is thought to be due primarily to the reduction of childhood mortality from infections.

Statistics vary considerably, but most authors agree that 90 to 97 per cent of malignant growths in childhood are sarcomas and 90 to 95 per cent of malignant growths of adult life are carcinomas.

It is evident that the various malignant growths of childhood have distinctive individual identities and are considerably different from adult tumors, of which the early writers generally considered them miniature counterparts.

One hundred and sixty-four malignant neoplasms have been diagnosed at Milwaukee Children's Hospital during the past 25 years. There were 57,323 admissions in this period, making 1 case of cancer for every 350 admissions to the hospital.

There were 36 miscellaneous malignant tumors in this group. These will be considered in this paper and they include sacrococcygeal tumors, retroperitoneal tumors, tumors of the parotid region, tumors of the gastrointestinal tract, gynecologic tumors, peripheral nerve tumors, and fascial tumors.

Sacrococcygeal Teratoma

Ten cases of sacrococcygeal teratoma have been diagnosed at Milwaukee Children's Hospital, all in the past 10 years. Seven of these were benign tumors, and malignant changes were found in 3 cases, in all 3 of which the spread was by direct extension, could not be entirely removed during operation, and ended fatally.

The youngest patient was operated on at 3 days of age and the oldest at 3 years. All but three tumors were first evident as a mass near the anus and over the sacrum at the time of birth. Two of the three which were not evident at birth were found to be malignant. All of the tumors noted first at birth gradually grew with the patients. Two, however, did not begin to grow until one year after they were first seen.

All of the patients with malignant growths which ended fatally were over 18 months old when they came to surgery. Two of these had had evident tumors since birth. The third patient had had no external evidence of a tumor until three months before she was admitted, at which time a tumor mass attached to the inside of the sacrum was found. She had, however, been constipated off and on since birth, and no examination was done to determine whether there might be a mechanical block at the rectum.

In 3 cases of benign tumors there were an associated spina bifida and meningoceles with paralysis of the legs. Urinary and rectal incontinence resulted in another case of a benign growth after surgical removal of the tumor.

Conclusions.—Sacrococcygeal teratomas should be removed as soon as possible after they are first discovered and, when necessary, the coccyx and part of the sacrum may be removed with the tumor, special care being taken to preserve the adjacent nerves.

Failure of the tumor to enlarge should not prevent early operation, since two of the three malignant tumors were obvious at birth but did not begin to enlarge until after one year of age.

Retroperitoneal Tumors

Several types of retroperitoneal tumors are found in children. These fall into two classes; neuroblastomas and sarcomas. The symptoms, signs, and prognoses of these two groups are the same. They differ only in microscopic make-up and site of origin.

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

Retroperitoneal Neuroblastoma

The neuroblastoma, sometimes called neurocytoma, arises from the sympathetic neuroblast. It can occur wherever sympathetic nerves are found, the adrenal medulla being the most common site. It is the second most common tumor in childhood that causes abdominal enlargement. Wilm's tumor is the most common.[8]

Nine cases of neuroblastoma have been diagnosed at Milwaukee Children's Hospital in the past 18 years, about one for every 5,000 admissions. The youngest patient was 2 months old, the oldest was 7 years, the average being around 4 years. The usual symptoms were abdominal enlargement and digestive disturbances. Frequently, an abdominal tumor could easily be palpated. In many cases the first symptoms were due to distant metastasis in the brain, skull, and liver before the primary tumor was discovered.

In all of the 9 cases the tumors resulted in metastasis and ended fatally.

Seven tumors were found to be primary in the adrenals, one in the celiac axis and one in the lumbar sympathetic nerves.

Retroperitoneal Sarcoma

There were five retroperitoneal tumors diagnosed as sarcomas of indeterminate origin. The patients were from 1 to 7 years of age.

As in the retroperitoneal neuroblastoma. the first symptom was always enlargement of the abdomen from tumor growth or was a manifestation of metastatic spread. All tumors metastasized before they came to surgery and all ended fatally.

Conclusions.—Retroperitoneal neuroblastomas and sarcomas are highly malignant tumors which metastasize early and have a very poor prognosis.

Usually the earliest symptoms are due to enlargement of the tumor in the abdomen or to distant metastasis. Occasionally, however, vague abdominal and back pains and digestive disturbances such as constipation are noted before abdominal enlargement is evident. The only hope in detecting them before metastasis takes place is to investigate such unexplained symptoms early.

Tumors of the Neck Parotid Region

Localized swelling in the neck of children can be due to a variety of cysts, infections, and tumorous growths.

The cysts are usually thyroglossal, branchial, or hygromas and may also be the site of infection. Their position and characteristics are usually diagnostic. Infections are usually self evident and invariably involve the lymph nodes. The majority of tumorous growths are due to involvement of the lymph nodes in such conditions as Hodgkin's disease, but there are some tumors which are concerned with the branchial apparatus and parotid glands. These are quite rare in children, but, nevertheless, do occur.

Five so-called mixed tumors of the parotid region have been seen at this hospital. They were all in boys, ages 3, 3, 4, 6, and 10 years.

Two of these were slowly growing tumors and considered to be non-metastasizing. The other three were malignant and two of them had already invaded the underlying bone. One of these had also metastasized to the brain. In all of these the mass in the neck was observed for considerable periods of time, some as long as a year before operation. One malignant tumor was not removed extensively enough and a recurrent growth had to be removed in four months.

Conclusions.—Malignant tumors do occur in the parotid region of the neck in children. These are usually noted early, but are watched for too long a period.

Tumors in this area should be investigated early and other nonmalignant swellings ruled out with all possible speed. Then surgical treatment should be resorted to.

Surgical procedures usually tend to be too conservative because of fear of injury to the facial nerve. If a solid tumor is found and it is well encapsulated without involvement of the nerve, conservation is indicated. If the tumor appears malignant and involves the nerve or if removal is hindered by the presence of the nerve, any branch or even the main trunk of the facial nerve must be sacrificed. Tumors in this region are notoriously radioresistant.

Gastrointestinal Tract

Malignant tumors of the gastrointestinal tract in children are not common. Various series[9] report them around 1 to 2 per cent of malignant tumors.

In the past 20 years only four malignant lesions of the gastrointestinal tract have been seen at this hospital. They were a transitional cell carcinoma of the pharynx, a fibrosarcoma of the palate, a fibrosarcoma of the mesentery involving the intestinal wall, and a primary liver cell carcinoma.

Fetid breath was the first symptom of both the lesion of the pharynx and the one of the palate. The first was observed for a long period, and, when surgical treatment was finally resorted to, the lesion was inoperable. The lesion of the pharynx was biopsied shortly after discovery and then removed completely, with full recovery.

The case of mesenteric fibrosarcoma was first manifested by failure of the patient to gain weight and by fever for about six months before operation. A mass the size of an orange was noted shortly before the surgical procedure, but at operation the tumor could be only partly removed because of local spread.

Abdominal enlargement and jaundice were the first indications of the primary liver cell carcinoma. An exploratory laparotomy was done shortly thereafter, and a biopsy specimen was taken. The entire liver was involved.

Conclusions.—Malignancies of the mouth and pharynx are manifested by fetid breath. Such a symptom should be investigated promptly and any questionable lesions should be biopsied.

Primary liver carcinomas, fortunately, are rare in children. The involvement is usually beyond help when it is discovered.

Gynecologic Tumors

Of the gynecologic tumors seen in childhood the ovarian are most common. There have been eight ovarian tumors at Milwaukee Children's Hospital in the past 25 years, in girls from 3 to 11 years of age. Half of the growths were malignant, and the other half were dermoid cysts.

Three of the malignant lesions were carcinomas and one was a sarcoma. One of the carcinomas was part of a teratoma.

Frequency over several weeks' time was a prominent symptom in 2 cases. Vaginal discharge was present in another. In all cases the tumor was palpable in the abdomen or on rectal examination. In 2 cases spread had occurred before operation. In a third the patient died from a recurrence. The fourth patient is still alive after one year.

In 2 of the cases of the dermoid cysts the growths were twisted on the pedicle and were diagnosed by palpation preoperatively. In the other 2 the patients had had recurrent attacks of lower abdominal pain and the dermoid cysts were discovered when the appendix was found to be normal.

Our only other gynecologic malignancy was a prickle cell carcinoma of the vulva in a 4 year old child. This is a rare tumor, in that only one other one can be found in literature.

There had been some vaginal bleeding when the child fell on a bicycle seven months previous. This disappeared and the lesion was discovered shortly before the first in a series of three operations, one of which was for biopsy of the regional lymph nodes, which proved not to contain malignant cells. She is apparently well now; it has been six months since her last admission.

Peripheral Nerve Tumors

Peripheral nerve tumors in children, as in adults, are not uncommon. They are sometimes called "neurogenic tumors," but this is a misnomer, since they are actually derived from the nerve sheath rather than the nerve cell itself.

The following groups may be seen: (1) neuroma, (2) neurofibroma, (3) perineurial fibroblastoma, and (4) sarcoma.

Neuroma.—This tumor is usually seen at the site of a nerve interruption, such as in an amputation. It is not a true neoplasm, but an injury and repair lesion and contains both axis cylinder and sheath tissue.

Neurofibroma.—The neurofibroma is said to be among the most common tumors in adults[12] and is not uncommon in children. It is found as a soft nodule in the skin and may be a single isolated lesion or multiple, as in von Recklinghausen's disease, in which it is frequently associated with brown pigmented spots in the skin. It is said to arise from connective tissue of the nerve sheath. From 10 to 15 per cent are potentially malignant.

This condition has been diagnosed three times at Milwaukee Children's Hospital, all in the past three years. In 2 cases the lesions were single: one time in the shoulder, the other in the umbilical region. The third case was a typical case of von Recklinghausen's disease. None revealed malignant changes.

Perineurial Fibroblastoma.—This tumor is derived from the Schwann cell layer of the nerve sheath and is sometimes called a "Schwannoma" (Masson) or "neurilemona" (Stout). It may be found in any peripheral nerve region but most common in the spinal nerve roots and acoustic nerve. Usually there are no symptoms associated with this tumor unless they be due to pressure on the nerve in a confined space. It is usually first noticed as small mass which may be moderately tender to palpation.

Microscopically, there are two main types of benign tumors; the palisaded cell formation, which is usually encapsulated, and the reticular type, with incomplete encapsulation. Both are essentially benign, but in some series[5] the growths are reported as high as 30 per cent recurrent after removal, and 50 per cent of those recurrent were malignant and fatal.

Four perineurial fibroblastomas have been diagnosed at Milwaukee Children's Hospital. Two of these, occurring in the scalp and eye lid, were benign. Two others, of the leg and vulva, were slow growing and were completely removed without any recurrence. Both of these were becoming gradually larger.

Sarcoma.—Sarcoma of the nerve sheath, sometimes called neurogenic sarcoma, is generally considered to be the malignant analogue of the neurofibroma.[4] It varies from a slow growing, locally invading tumor to the fulminating, rapidly fatal type, which metastasizes widely.

There have been no such tumors diagnosed at Milwaukee Children's Hospital.

Conclusions.—Peripheral nerve tumors are not uncommon in childhood. They are usually manifested by slightly tender masses beneath the skin. They deserve more consideration than they usually get, because they are all potentially malignant. Those less than 1.5 cm. or less in diameter which are not growing may be left alone and examined periodically. Large tumors or those observed to be growing should be excised and if reported to be malignant should be widely removed.

Many advocate frozen section microscopic examination at the time of the initial removal.

Fascial Sarcoma

There were three sarcomas of the fascia in this series. They were of the fascia lata, posterior fascia of the knee, and plantar fascia of the foot.

The tumor of the fascia lata was in a 3 year old girl who had a mass just above the knee, gradually getting larger for several months. Removal with a wide margin of surrounding tissue resulted in a cure.

The tumor of the posterior fascia of the knee was in a 6 year old boy who had fallen three months before entrance and had injured the knee. Examination revealed a firm, nontender, lemon-sized mass in the popliteal space. A biopsy revealed fibromyxosarcoma, and the lesion was removed. Four years later there was a recurrence at the same site and a mid-thigh amputation was done.

The tumor of the plantar fascia was in a 3 year old boy who had had a gradually enlarging mass on the bottom of the foot for six months. It became painful to walk. Surgical removal was done, and the microscopic report of the tissue was nonmalignant. Six months later there was a recurrent growth at the same site, which was removed. This time the microscopic report was fibrosarcoma. The surgeon suggested amputation of the leg, but the father refused and large doses of x-ray were given. A follow-up four months later revealed no evidence of recurrence or metastasis.

Conclusions.—Sarcoma of the fascia occurs in children and may be associated with trauma.

When the diagnosis is made, wide excision should be done, since these tumors spread by invasion rather than metastasis.

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NATIONAL GASTROENTEROLOGICAL ASSOCIATION TO MEET IN NEW YORK

The National Gastroenterological Association will hold its fifteenth annual convention and scientific sessions at the Hotel Statler in New York City on October 9–11, 1950.

Among the outstanding speakers to present papers at the convention are Drs. Richard B. Cattell, Lahey Clinic, Boston; W. Stuart Harrington, Mayo Clinic, Rochester, Minn.; W. J. Merle Scott, Rochester, N. Y.; John B. O'Donoghue, Chicago; Maurice Feldman, Baltimore; and Edward T. Lewison, Baltimore.

At the annual banquet of the association, to be held at the Hotel Statler on Tuesday evening, October 10, the winner of the National Gastroenterological Association 1950 prize award contest for the best unpublished contribution on gastroenterology and allied subjects, will receive the prize of $100 and a certificate of merit.

Immediately following the convention, the association is conducting a course in postgraduate gastroenterology at the Hotel Statler, New York, on October 12–14.

Further information concerning the program and details of the course may be obtained by writing to the Secretary, National Gastroenterological Association, 1819 Broadway, New York, 23, New York.

Multiple Sclerosis and the State of Wisconsin

By HANS H. REESE, M. D., and EDWARD PIER ROEMER, M. D.
Madison

H. H. REESE

Doctor Reese, a 1918 graduate of the University of Kiel in Germany, is professor of neuropsychiatry at the University of Wisconsin Medical School and research assistant of the Wisconsin Psychiatric Institute, Madison.

Among the medical societies in which the doctor holds positions are: fellow of the American Medical Association; director, American Board of Psychiatry and Neurology; and fellow of the American College of Physicians and of the American Neurological Assn.

E. P. ROEMER

Doctor Roemer, assistant professor of clinical neurology at the University of Wisconsin Medical School, received his medical degree from Cornell University Medical College, New York, in 1934. He remained at the institution as an instructor in neurology from 1937 to 1942, when he entered the Army. He now carries on a private practice in neurology and is the director of the Wisconsin Multiple Sclerosis Clinic in Madison.

MULTIPLE sclerosis presents a real challenge to the physician, layman, and social agencies of Wisconsin, because of the prevalence of the disorder in the Great Lakes region. The disease is characterized by the widespread, scattered involvement of the central nervous system principally with two types of pathologic features: (*a*) the degeneration of the myelin sheaths with the more common preservation of the axis cylinders and (*b*) the extensive, widely disseminated patches by glial proliferation. The clinical picture reflects the regional pathologic features of the widespread focal changes in the brain and spinal cord or both, depending upon the preservation or the destruction of the functioning axons. Multiple sclerosis is an insidious disease, occurring episodically with exacerbations and remissions. Notably, with each exacerbation, there is a steady relentless progression of the residual clinical disability. If the axis cylinders are finally destroyed, further remission of the disease from the affected parts does not occur.

Multiple sclerosis constitutes a real problem in the state of Wisconsin, for our state lies in the multiple sclerosis belt, which comprises the states in the Great Lakes area and particularly those situated in the colder northern regions and including Canadian provinces (see fig. 1). The cause of the high incidence of the disease in Wisconsin is not known. Several factors of significance are recognized. On the basis of climatology and geography on a world-wide basis, it is known that multiple sclerosis occurs more frequently in the temperate zones. This is borne out by the geographic studies above and below the equator. It is almost unknown in the tropics and Asia. The morbidity rate increases above the thirty-fifth parallel, with a further greater incident rate north of the critical fortieth parallel. The state of Wisconsin lies between the forty-second and the forty-seventh parallel.

The crude death rate for multiple sclerosis in the United States for the year 1946 was 1.0 per hundred thousand, with the Wisconsin death rate estimated during the same period as 1.4 per hundred thousand. This figure can represent only a trend, inasmuch as no accurate figures are available in regard to the mortality of multiple sclerosis at this time. As yet the diagnosis is not reportable, and it is rarely given as the primary cause of death. Only six other states are credited with a higher mortality rate for multiple sclerosis during this period; this may be due to the fact that in three of these states accurate statistical surveys were made.

The morbidity figures are still more difficult to evaluate, because of the uncertainty and, in the absence of specific diagnostic tests, the difficulty in diagnosis, and again because multiple sclerosis is not reportable. The mean average in the United States has been conservatively estimated at 5 per hundred thousand. The incidence of known cases in Wisconsin is estimated at 8 per hundred thousand. In the years from 1945 to 1950 approximately 39,500 patients with all types were admitted to the Wis-

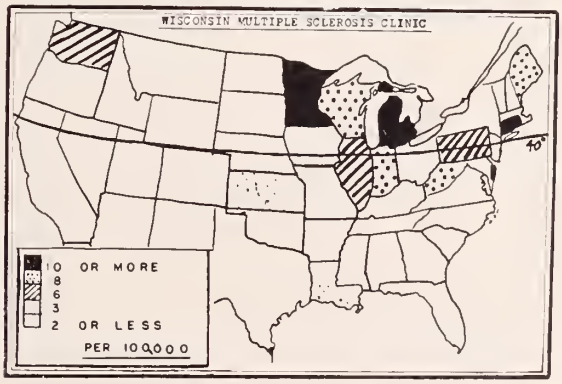

Figure 1 (from Peterson)

consin General Hospital. Of these, 253 patients were diagnosed as suffering from clearcut multiple sclerosis, representing the relatively high incidence of 6.3 per cent. This figure represents new admissions and does not include the readmissions of patients in old cases. In a comparable series in the Boston City Hospital, a similar figure was obtained, which exceeded the admission rate for poliomyelitis, bacterial endocarditis, Hodgkin's disease, and other disorders more widely known than multiple sclerosis. A survey has been made of the geographic location of known cases in Wisconsin. Comparisons were made between the urban and rural incidence and the implication of certain counties. No substantial difference was found between urban and rural life. No particular counties or areas within the state could be considered in any way "endemic" areas of the disease. The higher incidence in urban areas and in certain counties merely reflected the increased density of population in those areas (see fig. 2).

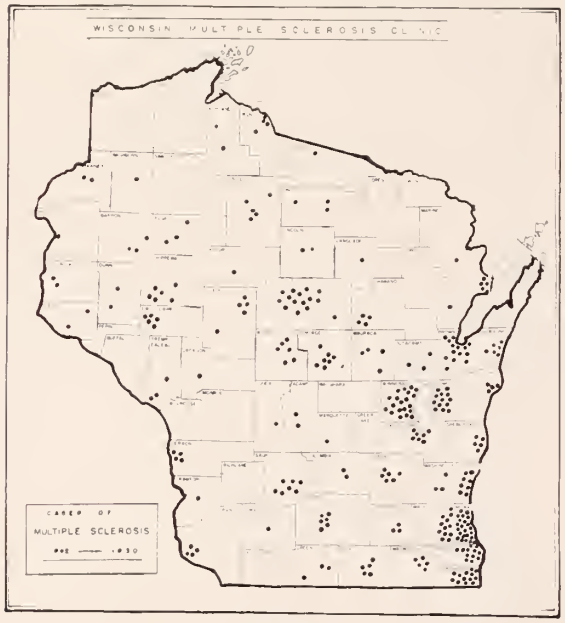

Figure 2

Another factor which accounts for the prevalence of multiple sclerosis in Wisconsin is the racial stock comprising its population. It is known that there is a high incidence of the disease in Northern Europe, where the morbidity rate is estimated at 200 per hundred thousand in contrast to 50 per hundred thousand in the United States. The incidence among racial types in a study by Davenport of the United States has been computed per hundred thousand as follows:

Finnish	29
Scandinavian	16
German and Austrian	10
French–Canadian	8
'Mountain Whites'	7
Indian	1

A similar study by Bailey yields the following:

Scandinavians	12.5
French	10.7
Slav	9.0
German	8.3
Scots	8.2
English	8.1
Irish	7.9
Italians	5.2
Negroes	3.5

In Wisconsin a statistical survey based on the 1940 census shows that 90 per cent of the population are native-born whites; 9.2 per cent foreign-born whites; 3 per cent Negroes; and .4 per cent representing other groups; and the original racial stock of the white, native, and foreign born is derived overwhelmingly from Northern European countries. The source of Wisconsin's population may constitute a vulnerable factor in the high incidence of the disease in our state.

An attempt has been made to correlate the incidence of multiple sclerosis on an epidemiologic vector basis in relation to the streams and rivers of Wisconsin. No significant correlation could be found with the present limited number of cases available for statistical purposes.

These statistics are reviewed in an effort to show that multiple sclerosis constitutes an important disease entity in the state of Wisconsin. It will be shown that the disease and its course present many socioeconomic as well as medical problems. The onset is chiefly in the second and third decades, with visual, sensory, or motor symptoms. It has been determined that in the United States the average duration of the disease is 27 years, with a mean age at death of 45.3 years. This average exceeds the life expectancy of patients in European countries, where the average span of life ranges from 10 to 15 years only. Therefore, we conclude from our study that in Wisconsin at a given time there are more than 500 known cases with a very high number additionally of subclinical, "probable," "doubtful," or unrecognized cases. The problem obviously challenges the medical profession and is of great concern to the layman and social state agencies. While no figures are available at present for the state of Wisconsin as a whole, the yearly admission rate to the Wisconsin General Hospital and the ambulatory outpatient service, have shown an alarming increase. The table below shows the admission rate of new cases from 1940 to 1950.

Admission Rate of New Cases, 1940–1950

1940	15	1946	39
1941	22	1947	43
1942	23	1948	48
1943	23	1949	53
1944	21	1950 (January to July)	31
1945	28		

Thus, when one considers that there is a high incidence of multiple sclerosis in Wisconsin, that the disease is disabling without affecting the longevity of the individual, and that medical treatment and rehabilitating facilities are most inadequate, a pro-

vocative situation arises. The etiology of multiple sclerosis remains unknown. The number 1 problem for the physician is to recognize the disease early and to employ every therapeutic measure available to insure the most effective means of maintaining a patient in remission at his highest physical and economic efficiency.

It is not within the scope of this paper to discuss the many theories of etiologic and precipitating factors. In the remitting nature of the disease lies our greatest hope for therapeutic achievement at the present time, to effect and maintain remission in the patient. A rational outline of the requirements for the handling of multiple sclerosis is given: 1. An accurate evaluation of the patient's general physical condition, personality reactions, and neurologic status is essential.

2. It is necessary to maintain the individual as a well integrated personality by practical psychotherapy and continuation of his daily work routine and social activities commensurable with his physical condition.

3. Regardless of the primary cause, one is dealing essentially with an inflammatory or degenerative disease of the central nervous system, which terminates in the destruction of neuronal axons and in the formation of sclerotic plaques. It is, therefore, our goal to increase the blood supply to the central nervous system by the use of vasodilators such as aminophyllin, papaverine, nicotinic acid, and histamine diphosphate intramuscularly or intravenously.

4. The vitamin and mineral requirements necessary for the balanced functioning of the neuronal enzymes and metabolic activity must be supplied in adequate amounts. Thiamine chlorides, nicotinic acid, ascorbic acid, B_{12}, and crude liver extracts are administered. Proper medication reduces the disturbing paresthesias in most instances.

5. The maintenance of proper hygienic measures and the avoidance of fatigue and of extremes in temperature, especially cold, are necessary. Pregnancy represents an additional burden and should be avoided or at least carefully supervised during the puerperium.

6. Physical therapy is essential in the successful management of multiple sclerosis and enables the patient to maintain his muscular system at its optimum condition to overcome the frequently present dyscoordination of the arms and legs.

7. ACTH, Tolserol or myanesin, curare preparations, quinine sulfate as well as tonics have been of no or of insignificant value. In a small number of cases in which feasible, we have recommended the moving to and living in a warm, more stable climate, but this trial has been without effect on the course of the disease.

We contemplate to conduct a survey of the incidence of multiple sclerosis in the state of Wisconsin with the cooperation of the medical profession. The plan, procedure, and supervision of the survey postulate: (1) the report of all suspected or diagnosed cases of multiple sclerosis to the Wisconsin Multiple Sclerosis Clinic; (2) referral of patients with "probable," "doubtful," "unlikely" conditions to the newly established Multiple Sclerosis Clinic for diagnostic evaluation as ambulatory outpatients; and (3) referral of patients with "true," "certain," "sure" multiple sclerosis for study and research investigation at the Wisconsin Multiple Sclerosis Clinic, with the recommendation of a treatment schedule to be carried out at home by the referring physician.

In the October issue a detailed plan of the Wisconsin Multiple Sclerosis Clinic will be published.

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AMERICAN PUBLIC HEALTH ASSOCIATION TO CONVENE IN ST. LOUIS

The seventy-eighth annual meeting of the American Public Health Association and meetings of 32 related organizations in the field of public health and preventive medicine will be held in Kiel Auditorium, St. Louis, October 20 to November 3. More than 400 speakers and discussants will participate in the scientific programs under development by the thirteen sections of the association

Details of the program may be obtained from Dr. Reginald M. Atwater, Executive Secretary, American Public Health Association, 1790 Broadway, New York 19, New York.

Nephritis*

BY B. J. PETERS, M. D.
Milwaukee

B. J. PETERS

Doctor Peters, a graduate of Marquette University School of Medicine, is in the private practice of internal medicine in Milwaukee. He is chief of medicine at the Milwaukee County General Hospital and serves as assistant professor of clinical medicine at Marquette University School of Medicine and as a consultant in internal medicine at the Veterans Administration Hospital, Wood. He is a diplomate of the American Board of Internal Medicine.

THE patient was a 17 year old white male, who entered the hospital for the first time on April 17, 1947. The history given by the parents was that the youngster had had a cold two weeks prior to admission. One week later he developed puffiness of his ankles and face and a drainage from his right ear. His urine became cloudy and he became listless. His past history was negative. On entrance into the hospital the patient had moderate generalized edema. His eyelids were puffy. There was a purulent drainage from his right ear. The heart beat was rapid and regular. The lungs were clear. The abdomen was distended. The extremities revealed a 4 plus edema. Blood pressure was 142/90. Examination of his urine on admission revealed 4 plus albumin, specific gravity 1.009, 10 to 15 red blood cells, 20 to 25 hyaline casts, and 40 to 45 granular casts. The quantitative albumin was 16.7 Gm. in 24 hours. The blood chemistry showed a nonprotein nitrogen content of 89 mg. per cent, carbon dioxide–combining power was 37 volumes per cent, chlorides 534 mg. per cent, cholesterol 260 mg. per cent, total proteins 4.86 Gm., albumin 3.50 Gm., and globulin 1.36 Gm. The Volhard concentration test revealed a maximum concentration up to 1.018. Phenolsulfonephthalein excretion was 40 per cent in one-half hour, 15 per cent in one hour, a total of 55 percent. Urea clearance was 20.8 per cent of normal. The electrocardiogram revealed myocardial damage. A chest x-ray was normal. The diagnosis was acute glomerular nephritis.

Surgical drainage of the otitis media was performed. The remainder of treatment will be included in the discussion. After several weeks, instead of improving, the patient became worse. The edema and albuminuria increased. His blood pressure began to climb and had risen to 160/120. During this stage there developed several generalized convulsions, which responded to magnesium sulfate therapy. Following this period there developed a gallop rhythm and pulmonary edema. This responded to xanthine diuretics and digitalization. About one week later ascites and pleural effusion became the most distressing objective finding. Repeated paracenteses were done to correct this. It was at this time also that the quantitative albumin in the urine had risen to a total of 40 Gm. per day. The total blood protein content dropped to 3.10 Gm. Albumin was 2.5 and globulin, 0.6 Gm. The blood chloride content was 572 mg. per cent and the cholesterol level rose to 489 mg. per cent. The Volhard concentration was 1.019. Phenolsulfonephthalein excretion was 35 per cent in one-half hour. Urea clearance was 40 per cent of normal. Following this stage the patient began to make an apparent improvement, for his edema began to disappear, the total 24 hour albumin excretion dropped to 1 Gm. per day, his total blood protein level rose to 7.3 Gm., the nonprotein nitrogen content dropped to 42.8 mg. per cent and the cholesterol level dropped to 230 mg. per cent. Urea clearance came up to 70 per cent of normal. The Volhard test remained at 1.018, and the patient was discharged to convalesce at home after six months in the hospital. Since his discharge he has returned seven times, with exacerbation of his renal lesion. He continues to have albuminuria, the 24 hour albumin excretion being 9.0 Gm. per 24 hours. His nonprotein nitrogen level now is 50 mg. per cent, creatinine 1.8 mg. per cent, chlorides 475 mg. per cent, total protein 5.75 Gm., and blood pressure 140/94.

This patient demonstrates the changing clinical picture which is seen so frequently in nephritis. The picture at any one period is dependent on the extent and progression of the glomerular, tubular, vascular, or interstitial lesion. This injury subsequently leads to severe and important disturbance of renal function.

In nephritis five syndromes are recognized: (1) urinary, (2) edema, (3) hypertension, (4) azotemia, and (5) uremic, the uremic being subdivided into the genuine uremia and false uremia, or the hypertensive encephalopathy syndrome. In the study of patients with nephritis, one finds that not all syndromes are present in every case; any one or a combination of these syndromes may exist. As a rule, the urinary syndrome is the only one that is present nearly always. The other four are present in varying percentages, in conjunction with the urinary syndrome. Some patients have hypertension; others have only the urinary findings and uremia. Some have the urinary syndrome plus convulsions, which are due to edema of the brain, which in turn is secondary to the hypertension. Many have the urinary picture and edema, without any of the other syndromes being present. Some have total anuria plus a combination of any of the above syndromes.

During the acute phase, certain treatments are carried out; the first in importance, of course, is bed rest, and this should be absolute until such time as the urinary constituents disappear or remain unchanged, until the sedimentation rate returns to normal or remains unchanged, and until the patient maintains a steady weight, blood cell count,

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

and blood pressure. The next in importance is the use of antibiotic therapy and surgical intervention to correct any existing infections. Thirdly, antihistaminic therapy is used to prevent the possible antigen-antibody reactions, which, according to some, take place in nephritis. Fourthly, the cardiac failure should be corrected by the same measures as are taken to treat cardiac failure due to any other cause excepting that use of mercurials should be avoided during the acute phase of nephritis and during the anuric stage of the disease. Fifth, supportive measures should be given, which include blood transfusions, iron, and vitamin therapy.

The next important and most abused portion of treatment is the dietary management of the nephritic patient. It is this phase of treatment that I would like to discuss in greater detail. In the dietary management the urinary findings and the protein loss, plus a knowledge of the levels of blood urea nitrogen, nonprotein nitrogen, total proteins, blood chlorides, urine chlorides and carbon dioxide-combining power, are of extreme importance,—for it is by the knowledge of these that we can regulate the dietary needs. During the initial stages of a patient such as reviewed, with typical urine findings, edema, nitrogen retention, and hypertension, diet is relatively unimportant, as the patient will not eat because of nausea and vomiting. Parenteral fluids in the form of 5 per cent glucose are all that is needed. The quantity to be used is based on the urinary output. If anuria is present, 0.6 cc. per kilogram per hour or approximately 1,000 cc. per day, are needed in a 70 kg. man.

Greater quantities of fluid are added when the urinary output returns. Overhydration can be gauged very effectively by weighing these patients. Amino acid therapy should not be used, as it will add to the nitrogenous wastes, and the kidneys already are unable to handle those present. When the patient recovers from this initial insult, he begins to eat, urinary output increases, and then diet becomes of extreme importance. At this stage in the acute phase, protein restriction to as low as 25 to 30 Gm. per day may be desirable, or about 0.5 to 0.75 Gm. per kilogram per day is the maximum quantity to be used. This marked reduction will be enough to maintain proper nitrogen balance without producing excess nitrogenous wastes and acid metabolites for the kidneys to excrete.

Large amounts of fluids are not necessary. Fluids would cause a diuresis and thereby waste essential electrolytes. Carbohydrate and fat intake should be increased to supply the necessary caloric requirement up to 3,000 calories per day if needed.

The next important item in the diet is salt, and this should be restricted from the beginning of the acute disease. The chlorides and bicarbonate content of the serum, however, should be analyzed periodically, especially if the patient is vomiting. If the chloride level falls, salt has to be reintroduced and at times normal saline or 2 per cent sodium chloride may have to be used with caution to replace the quantity lost.

If heart failure occurs in the acute phase, as it does in a good percentage of cases, rigid salt restriction is indicated; when diuresis occurs and edema is gone, some salt may be introduced.

As the acute nephritis becomes better and the urinary and other findings begin to disappear, the proteins are gradually increased up to a normal intake of 1 Gm. or more per kilogram per day, depending upon the age of the individual and the individual's preference. Salt should be restored gradually when edema disappears, to avoid recurrence of edema. We usually increase their intake by 2 Gm. for two to three days. If there is no increase in edema or weight of the individual and there is no decrease in urinary output or rise in blood pressure, the salt is increased to 5 Gm. a day and eventually a normal quantity is permissible.

A regime such as has been outlined may be necessary in the fulminating case, such as this one. However, in those not so severe, the diet may be entirely different. If only the urinary syndrome is present, salt restriction may not be necessary and it is questionable whether protein restriction need be carried out. Patients with a mild disease will handle a normal protein intake, providing they have normal urine output. It is when oliguria sets in that protein restriction becomes important.

As glomerulonephritis progresses and the patient passes into the nephrotic phase, as this boy did, one is confronted with a problem which is quite different from that of the acute phase. For in this stage of the disease the patient may not have hypertension, or hematuria, or nitrogen retention, but does have marked edema, hypercholesterolemia, albumin globulin reversal, and large quantities of albumin in the urine, at times as high as 20 to 40 Gm. per 24 hours, as was present in our patient. Whether nephrosis occurs as an independent disease is controversial. Nevertheless, it is one of the stages through which glomerulonephritis may progress and is also regularly encountered in amyloid degeneration of the kidneys. In any case, its effect on water and salt metabolism is essentially the same, regardless of its origin. In the treatment of these individuals we attempt, first, to promote diuresis and, secondly, to correct the hypoalbuminemia. Salt restriction is preeminent and this has to be rigid. The extensive edema in these patients is on the basis of a depletion of the serum albumin, and it is this factor that we try to improve by dietary management. These patients are given diets high in protein up to 3 Gm. per kilogram. This quantity is the upper limit that most individuals will take, especially when salt is restricted. It is difficult to raise the protein level in the blood if excretion is 10 Gm. of protein or greater; if 15 Gm. or over, it is impossible to build the serum albumin content by diet. Nevertheless, depletion of serum albumin means depletion of all protein stores in the body,

and protein feeding is the only way we can keep up the patient's nutrition until nature comes to his rescue. Nature then may heal the glomeruli through which this large quantity of protein is leaking, or a fibrosis of these glomeruli may result and the protein loss is stopped. I feel that this occurred in this patient. The edema may then clear and the patient begins to show clinical improvement, but in reality the kidney has been more extensively damaged. Intravenous protein hydrolysate or amino acids are of no value in attempting to build up the protein depletion. These are of value only in correcting the nitrogen crises which result from depletion of plasma nitrogen, as demonstrated by Fahr. Some may wonder about the use of concentrated salt-free serum albumin at this stage. We feel this is not advisable, as it is excreted as quickly as it is administered and is too closely to be eliminated in the urine.

I have attempted to give you an idea of the complexity of the treatment and dietary problem in the patient with nephritis. Diet is a very important part of the treatment of these individuals. A routine rigid dietary program, patterned in such a way as to be applicable to all cases of nephritis, is a grave error, for many times this type of program may lead to severe degrees of malnutrition, anemia, constitutional disturbances, and vitamin deficiencies in the patient with nephritis. The patient's renal lesion must be evaluated in its entirety, and then a more rational and physiologic approach in the prescription of treatment and diets can be achieved.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the association, which will be held in Columbus, Ohio, May 24–26, 1951, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3,000 words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado, not later than March 1, 1951. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the prize award essay by the author, if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association.

WISCONSIN SECTION OF INTERNATIONAL COLLEGE OF SURGEONS TO MEET IN MILWAUKEE

The Wisconsin Section of the Interntaional College of Surgeons will meet at the Hotel Schroeder, Milwaukee, on October 1 for a dinner and scientific program.

Following a business session at 5:30, at which officers will be elected, a dinner will be served. The scientific program, beginning at 8 p. m., will be as follows:

"Surgery of the Extrahepatic Biliary System"—Maurice G. Rice, M. D., Stevens Point.

"Endometriosis"—Eugene L. Dallwig, M. D., Milwaukee.

Report of the meeting, International College of Surgeons in Buenos Aires, Argentina—William C. Gnagi, M. D., Monroe.

The Cleveland Annual Assembly, Remarks—Arnold S. Jackson, M. D., Madison, secretary, United States Chapter.

Hypoglycemic Reactions in Diabetes*

BY MAURICE HARDGROVE, M. D.
Milwaukee

MOST of my remarks concern the hypoglycemic reactions occurring in patients who have diabetes. The term "coma" should not be used to mean a hypoglycemic reaction. The term "insulin reaction" should be reserved to mean local skin reactions and allergic manifestations of the various insulin preparations. It is well to remember that a hypoglycemic syndrome, whether caused by insulin in a diabetic patient or some other cause in a nondiabetic person, may resemble epilepsy, acute alcoholism, encephalitis, psychoneurosis, or angina pectoris. Hypoglycemic reactions were noted in the pre-insulin starvation treatment of diabetes. Doctor Root is credited with the recognition of a severe hypoglycemic reaction in a starved diabetic patient and correction of the condition by the administration of orange juice.

The hypoglycemia we see in the person with diabetes is due to an overabundance of insulin and is influenced by the lack of food or increased muscular exercise.

The reactions noted after administration of regular and globin insulin are more abrupt than those noted after protamine zinc insulin. The hypoglycemic attack may occur from half an hour to six hours after administration of regular insulin and from 8 to 12 hours or longer after use of globin insulin. The intake of food should follow within 20 minutes after the injection of regular insulin. Mid-afternoon feedings will prevent the globin reactions. Prompt administration of sugar, in the form of candy or orange juice rapidly corrects the overdose of regular and globin insulin. Occasionally one notes a prolonged effect of large amounts of regular insulin, quite similar to the protamine zinc reaction. This should be kept in mind in the management of severe and prolonged diabetic coma.

Long acting protamine zinc insulin may give a hypoglycemic reaction very much delayed, due to its slow absorption. The most difficult appraisal is early in the morning and in a patient who is unconscious. The urine may contain some sugar which has been released by the kidneys before the blood sugar has fallen. Thus one must bear in mind that a second specimen must be obtained if the diagnosis is in doubt. This accentuates the necessity for a physician to carry not only a urine sugar-testing tablet in his bag but also a catheter to be used in the unconscious patient. Many physicians avoid the hypoglycemic action of protamine zinc insulin by permitting the diabetic patient to spill a trace of sugar in the morning urine.

One must bear in mind that because of the long and irregular absorption of protamine zinc insulin there may be only temporary improvement in the condition of the hypoglycemic patient after the intake of sugar and one does not feel secure until the patient has been normal for several hours. Additional sugar is to be taken by the patient until he feels perfectly well or until sugar persists in his urine.

Accidents to the patient or to others may occur as the result of hypoglycemic reactions and they are to be avoided if the diabetic person is to retain his dignity in the community. The diabetic person, and especially the young person, who greatly increases his exercise on the week-end, should be instructed to eat additional food. Often in the regular daily maintenance of the young person with diabetes, it is wise for the patient to take a 5 Gm. cracker between meals to avoid hypoglycemic episodes. Each diabetic patient should have a card which carries the diagnosis and tells whoever finds him confused or unconscious to give sugar in some form and to call a physician. The physician must assume the responsibility for the reactions and protect the patient from erroneous legal judgments.

Apparently severe brain damage may occur from prolonged low blood sugar levels. A few of these have been reported in the psychiatric literature where the results of insulin treatment of mental patients are reported. There are reports of permanent mental defects and some deaths after the use of large amounts of insulin in patients wrongly diagnosed as being in diabetic coma.

It is also interesting to note that frequently nondiabetic psychoneurotic and psychotic persons react excessively to insulin. This was shown recently by Dr. Julius M. Meyer and Dr. Jack J. Levin at the Wood Veterans Hospital.

It has been suggested and there appears to be some merit to the work that many of the patients who are hard to control—the labile type—have abnormal brain patterns as seen on the electroencephalogram. Dr. Mabel Tuchscherer, a medical resident at Milwaukee County Hospital, studying this type of patient, has been encouraged by noting a more accurate control in some of the patients who have been placed on anticonvulsant therapy.

Functional as well as secondary hypoglycemia may occur in the nondiabetic person. The secondary hypoglycemia reactions are noted in exercise; undernutrition, primary or secondary; hypocorticoidism; anterior lobe pituitary hypofunction; liver disease; muscular dystrophy; renal glycosuria; and in abnormal mental states.

A most difficult syndrome to diagnose occurs as the result of an islet cell adenoma of the pancreas.

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* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949. Abstract of Comments, symposium on diabetes.

The organic type of hyperinsulinism produces progressively severe and more frequent attacks occurring during the night, and three hours after meals and are produced by exercise or lack of a meal. The fasting blood sugar is usually below 50 mg. and when the patient has had no food for 24 hours, it is below 30 mg. The blood sugar level falls below 30 mg. three hours after a dextrose tolerance curve in the properly prepared patient. Hypoglycemia apparently may also occur as the result of hypersecretory though otherwise normal islet cells. The relief of this condition is often improved by removal of a small pancreatic adenoma or by the removal of a large part of the pancreas. Alloxan is not indicated, because of its toxic effects on the liver. Functional types of hypoglycemia are helped by a low carbohydrate high protein diet.

THE WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

Hotel Schroeder, Sunday, October 1

PARLOR A, FOURTH FLOOR

2:00 p. m.: Business session and election of officers

3:00 p. m.: "A Survey of Anesthesia Practice in Denmark": Stuart C. Cullen, M. D., Associate Professor of Surgical Anesthesia, University of Iowa Medical School, Iowa City

5:00 p. m.: Social Hour

6:30 p. m.: Dinner

(All reservations for this meeting, and the dinner, should be directed to William Kreul, M. D., Secretary, Wisconsin Society of Anesthesiologists, Racine, Wisconsin.)

WISCONSIN CHAPTER OF AMERICAN COLLEGE OF CHEST PHYSICIANS

Hotel Schroeder, Sunday, October 1

CRYSTAL BALLROOM

No Registration Fee

1:00 p. m.: Registration: Crystal Ballroom Scientific Exhibits

2:00 p. m.: Scientific Session, Crystal Ballroom

"Newer Concepts in the Management of Patients with Bronchial Asthma, Including Experience with ACTH and Cortisone": Maurice Segal, M. D., director, department of inhalational therapy, Boston City Hospital; assistant professor in medicine, Tufts College Medical School, Boston

"Roentgenologic Detection and Identification of Intracardiac Calcifications": J. Edwin Habbe, M. D., associate professor of radiology, Marquette University School of Medicine, Milwaukee

"Carcinoma of the Esophagus": Philip Thorek, M. D., associate professor of surgery, Cook County Graduate School of Medicine; assistant professor of clinical surgery, University of Illinois College of Medicine, Chicago

"Endogenous and Exogenous Pulmonary Edema": Elston L. Belknap, M. D., associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee

"Therapeutic Improvement of Symptoms in Emphysema": Edwin R. Levine, M. D., attending physician, Michael Reese Hospital; formerly director of chest service, Michael Reese Hospital, Chicago; adjunct professor of medicine, New York Medical College

"Cardiac Catheterization": Howard B. Burchell, M. D., consultant in medicine, Mayo Clinic, Rochester, Minn.; assistant professor of medicine, Mayo Foundation Graduate School, University of Minnesota, Minneapolis

6:00 p. m.: Dinner Meeting, Pere Marquette Room

"Roentgenologic Aspects of Mediastinal Diseases": Lester W. Paul, M. D., professor of radiology, University of Wisconsin Medical School, Madison

OFFICIAL PROGRAM

MILWAUKEE — ★ — OCTOBER 1-4

STATE MEDICAL SOCIETY OF WISCONSIN

Official Annual Meeting Notices

■ ADMITTANCE BY BADGE ONLY: Participation in the Annual Meeting is limited to paid members of the State Medical Society of Wisconsin and certified guests. Secure your badge and program at the registration desk in the Milwaukee Auditorium before the scientific sessions begin. If you lose your badge another may be secured.

■ CERTIFIED GUESTS: Arrangements have been made with the hospitals to admit interns and key hospital personnel as guests *if previously certified.* Residents will be admitted upon certification of the hospital. Out-of-state physicians who are full dues-paying members of their county and state medical societies can secure guest badges by presenting their membership cards.

■ REGISTRATION: Secure your badge at the registration desk, at the entrance of Bruce Hall, Milwaukee Auditorium, Kilbourn Street entrance. Registration hours: Monday and Tuesday: 7:30 a.m. to 5:00 p.m.; Wednesday: 8:00 a.m. to 3:00 p.m.

■ TELEPHONE SERVICE: *At Milwaukee Auditorium:* During scientific sessions, calls directed to physicians other than Milwaukee doctors should be directed to special phones installed. The numbers are Broadway 2–2523 and 2–2524. Calls for Milwaukee physicians should be directed to the Physicians Service Bureau (Marquette 8–4131), and they will be directed to a special phone in the Auditorium located near the main meeting hall. *At the Hotel Schroeder:* Delegates can be reached during sessions of the House (Sunday: 2:00–5:30 p.m.; Monday: 6:30–8:45; Tuesday: 9:00–10:00 a.m.) by having calls directed to the phone on the fifth floor foyer of the Hotel Schroeder (Marquette 8–7250). Those attending luncheons can be reached in the same manner between 12:15–2:15 p.m. each of the three days of the meeting.

■ SPECIAL CONCURRENT EVENTS: *Sunday:* Meetings of the Wisconsin Chapter of the American College of Chest Physicians (Crystal Ballroom, Hotel Schroeder) and the Wisconsin Society of Anesthesiologists (Parlor A, Hotel Schroeder). Golf Tournament at North Hills Country Club, 12:00 noon, *Wednesday,* October 4. Reservations at Registration Desk, Milwaukee Auditorium. Dinner and awards at 7:30 p.m. Marquette University Medical Alumni Association: luncheon at Blatz Auditorium, *Tuesday* noon, Oct. 3. Reservations made through the Marquette University Medical Alumni Assn. office, 1533 W. Wisconsin Ave., Milwaukee. Max J. Fox, M.D., president, will be in charge of arrangements.

■ RESERVATIONS FOR ROUND-TABLE LUNCHEONS: Attendance limited as noted in program. Tickets can be secured at the Registration Desk in the Milwaukee Auditorium until 11:00 a.m. each day. If any tickets remain unsold they can be purchased at a special reservation table set up in the fifth floor foyer of the Hotel Schroeder at 11:30 a.m. each day.

■ DUPLICATE LUNCHEON TICKETS: If you have left your luncheon tickets at home please secure duplicates at the Registration Desk, as no one can be admitted to a luncheon without a ticket.

■ SPECIAL LUNCHEONS:

Monday: Past President's luncheon: Parlor G. By invitation only.
County Secretaries: East Room, fifth floor.

Tuesday: Special luncheon on personal tax problems: Crystal Ballroom.

Wednesday: Pathologists: Pere Marquette Room, fifth floor.

EENT: East Room, fifth floor.

■ MEDICAL MOTION PICTURES: Monday afternoon, all day Tuesday, and Wednesday morning a variety of medical motion pictures will be shown in Committee Room "D", on the second floor of the Milwaukee Auditorium, directly across from Plankinton Hall.

■ SESSIONS OF THE HOUSE: Opening session Sunday, October 1 at 3:00 p.m., buffet supper for all delegates, councilors, and officers at 5:30 p.m. Second session preceded by buffet supper in Pere Marquette Room, fifth floor, 5:30 p.m., Monday. Session from 6:30–8:45 p.m. Third session begins at 9:00 a.m., Tuesday, and will conclude around 10:00 a.m.

■ CLINICAL CONFERENCES: Three hospital staff conferences are to be held simultaneously at the Milwaukee Auditorium Monday morning. See program for details.

■ WISCONSIN WOMEN'S M.D. DINNER: The Wisconsin Women's Medical Society will hold a dinner meeting at 6:30 on Monday, October 2, in Parlor A, Hotel Schroeder. Two guest speakers will appear on the program. Dr. Katharine W. Wright, Evanston, Ill., regional director of the American Medical Women's Association will discuss "Whose Organization is the A.M.W.A.?" Amee Zillmer, of Madison, will speak on "New Trends in Social Hygiene," and her talk will be followed by a question and answer period. Reservations for the dinner should be sent to Dr. Alice Watts, 324 East Wisconsin Avenue, Milwaukee 2.

CONDENSED ANNUAL MEETING TIMETABLE

SATURDAY, SEPTEMBER 30

2:00 p. m.: Council Meeting: Parlor A, Hotel Schroeder

SUNDAY, OCTOBER 1

9:30 a. m.: Council Meeting: Club Rooms, Hotel Schroeder
12:00 m. : Council Dinner: Club Rooms, Hotel Schroeder
2:00 p. m.: Wisconsin Chapter of American College of Chest Physicians: Program: Crystal Ballroom, Hotel Schroeder
3:00 p. m.: Wisconsin Society of Anesthesiologists: Program: Hotel Schroeder
3:00 p. m.: House of Delegates, State Medical Society: East Room, Hotel Schroeder
5:30 p. m.: Buffet Supper for Delegates, Councilors, and Officers: Crystal Ballroom, Hotel Schroeder
6:00 p. m.: Wisconsin Chapter of American College of Chest Physicians: Dinner: Pere Marquette Room, Hotel Schroeder
6:30 p. m.: Wisconsin Society of Anesthesiologists: Dinner: Parlor E, Hotel Schroeder

MONDAY, OCTOBER 2

7:30 a. m.: Registration: Kilbourn Avenue Entrance, Milwaukee Auditorium
9:00 a. m.: Teaching Demonstrations: Milwaukee Auditorium—See Pages 798–799 for Programs
10:30 a. m.: Clinical Conferences: Milwaukee Auditorium
Children's Hospital Staff Conference: Walker Hall, Milwaukee Auditorium
Milwaukee County Hospital Staff Conference: Plankinton Hall, Milwaukee Auditorium
Veterans Hospital (Wood) Staff Conference: Engelmann Hall, Milwaukee Auditorium
12:15 p. m.: Scientific Round-Table Luncheons: Hotel Schroeder
2:30 p. m.: General Scientific Session: Plankinton Hall, Milwaukee Auditorium
3:30 p. m.: Recess to View Exhibits
4:15 p. m.: General Scientific Session: Plankinton Hall, Milwaukee Auditorium
5:30 p. m.: Buffet Dinner for Delegates and Officers: Pere Marquette Room, Hotel Schroeder
6:00 p. m.: House of Delegates, State Medical Society: East Room, Hotel Schroeder
8:30 p. m.: Informal Smoker and Entertainment: Crystal Ballroom, Hotel Schroeder

TUESDAY, OCTOBER 3

9:00 a. m.: House of Delegates, State Medical Society: East Room, Hotel Schroeder
9:00 a. m.: Teaching Demonstrations: See Pages 798–799 for Programs
10:30 a. m.: General Scientific Session: Plankinton Hall, Milwaukee Auditorium
12:15 p. m.: Scientific Round-Table Luncheons: Hotel Schroeder
2:30 p. m.: General Scientific Session: Plankinton Hall, Milwaukee Auditorium
3:30 p. m.: Recess to View Exhibits
4:15 p. m.: General Scientific Session: Plankinton Hall, Milwaukee Auditorium
5:30 p. m.: President's Reception for Dinner Guests: East Room, Hotel Schroeder
6:45 p. m.: Annual Dinner: Crystal Ballroom, Hotel Schroeder

WEDNESDAY, OCTOBER 4

9:00 a. m.: Teaching Demonstrations: See Pages 798–799 for Programs
10:30 a. m.: General Scientific Session: Plankinton Hall, Milwaukee Auditorium
12:15 p. m.: Scientific Round-Table Luncheons: Hotel Schroeder
2:30 p. m.: Section Meetings:
Internal Medicine: Plankinton Hall, Milwaukee Auditorium
Obstetrics and Gynecology: Juneau Hall, Milwaukee Auditorium
Ophthalmology and Otolaryngology: East Room, Hotel Schroeder
Pediatrics: Kilbourn Hall, Milwaukee Auditorium
Radiology: Walker Hall, Milwaukee Auditorium
Surgery: Engelmann Hall, Milwaukee Auditorium
1:30 p. m.: "Tee Off" of Golf Tournament: North Hills Country Club, Milwaukee

OPEN ONLY TO MEMBERS AND CERTIFIED GUESTS

A New Feature

DAILY TEACHING DEMONSTRA

1 OB MANIKIN DEMONSTRATIONS

SOUTH KILBOURN

MONDAY: D. J. WERNER, M. D., Milwaukee
Breech Presentation

TUESDAY: F. F. FRECHETTE, M. D., Janesville
Version and Extraction

WEDNESDAY: CHAS. W. MUELLER, M. D., Brooklyn, N. Y.
Management of The Occipito-posterior Presentation

While each demonstration will take up problems of special interest to those in attendance, special attention will be directed to these topics on the days specified: "Breech Presentation," Monday; "Version and Extraction," Tuesday; and "Management of The Occipitoposterior Presentation," Wednesday.

2 FRACTURE DEMONSTRATIONS

EXHIBIT HALL

Program planned by:
A. C. SCHMIDT, M. D., Milwaukee

Demonstrators:
PAUL COLLOPY, M. D., Milwaukee; CHARLES IHLE, M. D., Eau Claire; JAMES NELLEN, M. D., Green Bay; JOSEPH STONE, M. D., Milwaukee; GEORGE THOMAS, M. D., Janesville; C. W. CHRISTENSON, M. D., Racine

These demonstrations have been provided by the Wisconsin Orthopedic Society at the request of the Council on Scientific Work. Each day the demonstrations will feature compression fracture of the spine, fracture of the radius, lower end, and fracture of the ankle.

3 NEWBORN BLOOD TRANSFUSIONS

EXHIBIT HALL

STAFF OF
CHILDREN'S HOSPITAL
Milwaukee

This demonstration will concern itself with technics in giving blood transfusions, with special reference to blood replacement in erythroblastosis. Various phases, such as blood matching and technics particularly related to pediatric practice, will be featured.

4 CLINICOPATHOLOGIC CONFERENCE

NORTH JUNEAU

MONDAY: J. F. KUZMA, M. D., Milwaukee

TUESDAY: D. M. ANGEVINE, M. D., Madison

WEDNESDAY: J. B. MIALE, M. D., Marshfield

These daily clinics will present cases outlined in advance and distributed to those in attendance. This special teaching feature of the program will be supplemented by a gross tissue display, which will be held simultaneously in the exhibit hall.

2 Annual Meeting

EIGHT IMPORTANT TOPICS

ALL DEMONSTRATIONS
FROM 9:00–10:15 A. M.
MONDAY THRU WEDNESDAY

MON.: FREDERICK GEIST, M. D.
TUES.: PAUL SETTLAGE, M. D.
WED.: OTTO MORTENSEN, M. D.
University of Wisconsin Anatomy Department

EXHIBIT HALL

ANATOMY DISSECTIONS 5

This year the anatomy dissection will feature a demonstration of the nerves of the viscera and the surgical approaches to parts of the autonomic nervous system. This will consist of a dissection of the nerves of the neck, thorax, abdomen, and pelvis in one specimen.

MONDAY: S. A. MORTON, M. D., Milwaukee

TUESDAY: H. W. HEFKE, M. D., Milwaukee

WEDNESDAY: LESTER PAUL, M. D., Madison

WALKER HALL

X-RAY INTERPRETATIONS 6

General topics for discussion will be as follows:

Monday: Doctor Morton will discuss general radiographic problems, with special reference to bones and gastrointestinal tract.

Tuesday: Doctor Hefke will discuss mostly radiologic problems as related to children.

Wednesday: Doctor Paul will discuss problems with relation to the chest.

Those interested are invited to bring plates for discussion.

DEMONSTRATIONS ALTERNATING AT 20 MINUTE PERIODS

DEMONSTRATORS: KARL SIEBECKER, M. D.
GORDON GARNETT, M. D.

(Both associated with the Department of Anesthesiology, University of Wisconsin)

EXHIBIT HALL

ANESTHESIA DEMONSTRATIONS 7

The demonstrations will consist of two parts: (1) the mechanical factors in control of spinal anesthesia and (2) the physical factors involved in respiratory activity.

STAFFS OF
COLUMBIA HOSPITAL, MILWAUKEE
MILWAUKEE COUNTY HOSPITAL
MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

NORTH KILBOURN

THE ARTIFICIAL KIDNEY 8

Acute anurias of renal origin are usually self limited. Accepted forms of medical treatment which minimize nitrogen catabolism and avoid the complications of overhydration will be outlined. Electrocardiographic evidence of potassium intoxication which appears to be a factor in the cause of death will be demonstrated. The artificial kidney will be shown in operation and examples of its effectiveness in lowering the nonprotein nitrogen and potassium in the serum and of correcting congestive heart failure and hypertensive encephalopathy resulting from overhydration will be demonstrated.

Monday, Oct. 2 Highlights . . .

MONDAY, OCTOBER 2

To supplement the teaching demonstrations and exhibits described on pages 798–799, the Council on Scientific Work has arranged to have the staffs of Children's Hospital, Milwaukee County Hospital, and Veterans Hospital, Wood, present the following staff conferences simultaneously on MONDAY, OCTOBER 2.

SURGICAL–MEDICAL STAFF CONFERENCE

Staff of Milwaukee County Hospital — Plankinton Hall, Milwaukee Auditorium

Joseph M. King, M. D., Chairman, Surgical Section
Francis Murphy, M. D., Chairman, Medical Section

10:30 a. m.: DIAGNOSIS AND TREATMENT — TUMOR OF URINARY BLADDER: Robert S. Irwin, M. D.

10:42 a. m.: MEDICAL DIAGNOSTIC PROBLEM: Joseph A. Bartos, M. D.

10:54 a. m.: PLANTAR ULCER IN A DIABETIC TREATED BY PLASTIC SURGERY: Volney B. Hyslop, M. D.

11:06 a. m.: FEVER CONVULSION: M. G. Peterman, M. D.

11:18 a. m.: SPONTANEOUS RUPTURE OF THE SPLEEN: E. A. Bachhuber, M. D.

11:26 a. m.: SALT DEPLETION AS A COMPLICATION IN THE TREATMENT OF HEART FAILURE: P. G. La Bissioniere, M. D.

PEDIATRIC STAFF CONFERENCE

Staff of Children's Hospital, Milwaukee — Walker Hall, Milwaukee Auditorium

Frank J. Mellencamp, M. D., Chairman

10:30 a. m.: NEPHRITIS: Ted Buszkiewicz, M. D.

10:45 a. m.: DIABETES: Karl Beck, M. D.

11:00 a. m.: CONVULSIVE DISORDERS: Niels Low, M. D.

11:15 a. m.: COMMON SKIN LESIONS IN CHILDHOOD: Donald M. Ruch, M. D.

11:30 a. m.: HEMATOLOGIC CASES: Dann B. Claudon, M. D.

SUPPURATIVE PULMONARY DISEASES

Staff of Veterans Hospital, Wood — Engelmann Hall, Milwaukee Auditorium

Maurice Hardgrove, M. D., Chairman

10:30–11:00 a. m.: MEDICAL ASPECTS OF SUPPURATIVE PULMONARY DISEASES: George C. Owen, M. D., and Donald M. Willson, M. D.

11:00–11:30 a. m.: SURGICAL ASPECTS OF SUPPURATIVE PULMONARY DISEASES: Forrester Raine, M. D., and Wilson Weisel, M. D.

All presentations will feature use of patients.

General Program, Monday, Oct. 2

PLANKINTON HALL, MILWAUKEE AUDITORIUM

HUGH McCULLOCH, M. D.
Chicago

F. W. MADISON, M. D.
Chairman

FRANCIS D. MURPHY, M. D.
Milwaukee

2:25 p. m.: OPENING OF SCIENTIFIC PROGRAM
J. Wm. Truitt, M. D., President

2:30 p. m.: RECENT ADVANCES IN RHEUMATIC FEVER: Hugh McCulloch, M. D., La Rabida Jackson Park Sanitarium, Chicago
(Lecture sponsored by Wisconsin Heart Association)

3:00 p. m.: ACUTE NEPHRITIS AND LOWER NEPHRON NEPHROSIS: Francis D. Murphy, M. D., clinical professor and director of the department of medicine, Marquette University School of Medicine

3:30 p. m.: RECESS TO VIEW EXHIBITS

4:15 p. m.: MULTIPLE SCLEROSIS: A. B. Baker, M. D., professor and director of the division of neurology, University of Minnesota Medical School, Minneapolis
(Theresa Rogers Memorial Lecture)

4:45 p. m.: RECENT ADVANCES IN THE FIELD OF ANESTHESIOLOGY: Stuart C. Cullen, M. D., professor of surgery, chairman of the division of anesthesiology, University of Iowa College of Medicine, Iowa City

A. B. BAKER, M. D.
Minneapolis

STUART C. CULLEN, M. D.
Iowa City

GUEST SPEAKERS ON SECTION PROGRAMS

J. W. CONN, M. D.
Internal Medicine

WM. F. HUGHES, M. D.
Ophthalmology

H. DABNEY KERR, M. D.
Radiology

CHAS. W. MUELLER, M. D.
Obstetrics and Gynecology

SCIENTIFIC ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

MONDAY ★ HOTEL SCHROEDER ★ OCTOBER 2

FOURTH FLOOR MEETING ROOMS

*1. Parlor A: RHEUMATIC HEART DISEASE: Hugh McCulloch, M. D., LaRadida Jackson Park Sanitarium, Chicago

*2. Parlor B: COMMON NEUROLOGIC PROBLEMS: A. B. Baker, M. D., professor of neurology, and head of division of neurology, University of Minnesota Medical School

*3. Parlor C: NEWER DRUGS AND THEIR USES: W. S. Middleton, M. D., professor of medicine and dean, University of Wisconsin Medical School

4. Parlor D: ACUTE NEPHRITIS: F. D. Murphy, M. D., clinical professor and director of division of radiology, Marquette University School of Medicine

5. Parlor E: INFERTILITY: Roland Cron, M. D., professor and head of the department of obstetrics and gynecology, Marquette University School of Medicine

*6. Parlor F: ACTH AND CORTISONE: E. S. Gordon, M. D., associate professor of medicine, University of Wisconsin Medical School

7. Parlor H: VIRUS DISEASE PREVENTION: A. R. Zintek, M. D., director of preventable diseases, Wisconsin State Board of Health

8. Parlor I: PROBLEMS IN ANESTHESIA: Stuart C. Cullen, M. D., professor of surgery, chairman, division of anesthesiology, University of Iowa College of Medicine

SPECIAL LUNCHEON—FOURTH FLOOR

9. Parlor G: Past President's Luncheon: Guest luncheon for all past presidents of the SMS and President-Elect. By invitation only. No charge for luncheon.

* Luncheon filled—no more reservations available!

FIFTH FLOOR MEETING ROOMS

*10. Private Dining Room 507: PRESENT STATUS OF SURGICAL TREATMENT OF THYROID DISEASE: Carl Eberbach, M. D., clinical professor and director of division of surgery, Marquette University School of Medicine

11. Private Dining Room 508: MANAGEMENT OF HAND INJURIES: William Frackelton, M. D., assistant clinical professor of surgery, Marquette University School of Medicine

12. Private Dining Room D: RH PROBLEMS: Tibor Greenwalt, M. D., clinical instructor in medicine, Marquette University School of Medicine

*13. Committee Room: ERUPTIONS OF THE HANDS AND FEET: S. A. M. Johnson, M. D., professor of dermatology and syphilology, University of Wisconsin Medical School

14. Pine Room: RECENT ADVANCES IN HEMATOLOGY: John Hirschboeck, M. D., professor of medicine and dean of Marquette University School of Medicine

15. Pere Marquette Room: DISCUSSION OF SOME PROBLEMS OF GYNECOLOGIC PLASTIC SURGERY: Ralph Campbell, M. D., professor of obstetrics and gynecology, University of Wisconsin Medical School

SPECIAL LUNCHEON—FIFTH FLOOR

16. East Room: County Secretaries: Special luncheon for county secretaries, furnished by SMS, at which county officers will meet with SMS and AMA officials.

Note: No charge for this luncheon, so do not include payment in your reservation.

"SMOKER" PROVIDES VARIETY OF ACTS

Those fortunate enough to secure seats at the 1949 Annual Meeting "Smoker" will recall the high grade of entertainment offered. A similar program is being arranged for the 1950 Annual Meeting, with the "Smoker" scheduled for Monday evening, October 2 from 8:30–10:00 in the Crystal Ballroom of the Hotel Schroeder.

Following custom, this feature of the program will be open only to members of the State Medical Society, guests, and exhibit representatives. *Wives of physicians are expected to attend the Auxiliary buffet supper in the Empire Room of the Hotel Schroeder.* Because of limited seating capacity in the Ballroom, members are asked to please *not* bring their wives if they do not choose to attend the Auxiliary meeting.

While the complete program for the "Smoker" will not be determined until a later date, the following features have been contracted for, and will provide the backbone for a program of outstanding merit.

Music by STEPHEN SWEDISH and His Band

RITA OEHMER, Chicago

Chanteuse Supreme—Artistry and Personality

LEE MONTES' TU-TONES, Chicago

Recording and Television Stars—Comedy and Music

These and other acts will constitute the evening program. It will be a meeting you will enjoy and one in which you can sit around and relax with your friends.

The hall can only accommodate 500 seated at the tables, so if you want a seat we suggest that you plan to be in the Ballroom by 8:30 sharp.

General Program, Tuesday, Oct. 3

Morning Session:

9:00–10:15 a. m.: SPECIAL TEACHING DEMONSTRATIONS
See pages 798–799 for a description of these important teaching programs. All will be held simultaneously in the areas indicated.

10:20–11:50 a. m.: GENERAL ASSEMBLY—PLANKINTON HALL, MILWAUKEE AUDITORIUM

FRANCIS LEDERER, M. D.
Chicago

W. S. BUMP, M. D.
Chairman

10:20 a. m.: A TWENTY YEAR ANALYSIS OF HYSTERECTOMIES PERFORMED IN ROCK COUNTY: E. W. Reinardy, M. D., Janesville

10:50 a. m.: THE USE OF ANTIBIOTICS IN OTOLARYNGOLOGY: Francis L. Lederer, M. D., professor and head of the department of otolaryngology, University of Illinois College of Medicine

11:20 a. m.: ACUTE ASEPTIC MENINGITIS: W. D. Sutliff, M. D., Chief, Infectious Disease Section, V. A. Hospital, Memphis, Tenn.

W. D. SUTLIFF, M. D.
Memphis, Tenn.

SEE NEXT PAGE FOR TUESDAY NOON ROUND-TABLE LUNCHEONS

Afternoon Session:

DANIEL C. DARROW, M. D.
New Haven, Conn.

MICHAEL JORDAN, M. D.
New York City

T. O. NUZUM, M. D.
Chairman

2:30 p. m.: FLUID THERAPY WITH SPECIAL REFERENCE TO THE ROLE OF POTASSIUM: Daniel C. Darrow, M. D., professor of pediatrics, Yale University School of Medicine, New Haven, Conn.

3:00 p. m.: EARLY DIAGNOSIS OF UTERINE CANCER AND ITS MANAGEMENT: Michael J. Jordan, M. D., associate professor of clinical obstetrics and gynecology, New York University College of Medicine, New York City
(Lecture sponsored by Wisconsin Division, American Cancer Society)

3:30 p. m.: RECESS TO VIEW EXHIBITS

4:15 p. m.: THE SURGICAL MANAGEMENT OF THYROID DISEASES: Richard Cattell, M. D., Lahey Clinic, Boston

4:45 p. m.: RECENT ADVANCES IN THE TREATMENT OF RESPIRATORY DISEASES: Yale Kneeland, Jr., M. D., associate professor of medicine, Columbia University, New York City

RICHARD CATTELL, M. D.
Boston

YALE KNEELAND, JR., M. D.
New York City

SCIENTIFIC

ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

TUESDAY ★ HOTEL SCHROEDER ★ OCTOBER 3

FOURTH FLOOR MEETING ROOMS

*1. Parlor A: PSYCHOTHERAPY IN GENERAL PRACTICE: John Schindler, M. D., Monroe

*2. Parlor B: DRUGS IN THE CONTROL OF PAIN: Harry Beckman, M. D., professor and director, department of pharmacology, Marquette University School of Medicine

3. Parlor C: ANTIBIOTICS IN OTOLARYNGOLOGY: Francis Lederer, M. D., professor of otolaryngology and head of department of otolaryngology and rhinology, University of Illinois College of Medicine, Chicago

*4. Parlor D: VIRUS INFECTIONS OF THE NERVOUS SYSTEM: W. D. Sutliff, M. D., V. A. Hospital, Memphis, Tennessee

*5. Parlor E: SURGICAL TREATMENT OF ADVANCED CARCINOMA OF THE PELVIS: Michael J. Jordan, M. D., associate professor of clinical obstetrics and gynecology, New York University–Bellevue Medical Center, New York City

*6. Parlor F: THE MANAGEMENT OF HYPERTENSION: Chester M. Kurtz, M. D., associate professor of medicine, University of Wisconsin Medical School

7. Parlor G: CANCER OF THE PROSTATE: John B. Wear, M. D., associate professor of urology, University of Wisconsin Medical School

8. Parlor H: PULMONARY TUBERCULOSIS: A. V. Cadden, M. D., associate clinical professor of medicine, Marquette University School of Medicine

* Luncheon filled—no more reservations available!

FIFTH FLOOR MEETING ROOMS

9. Parlor I: NON-GLOMERULONEPHRITIC RENAL DISEASE: W. A. D. Anderson, M. D., professor of pathology, Marquette University School of Medicine

*10. Private Dining Room 507: NEWER DRUGS AND THEIR USES: Ovid Meyer, M. D., professor of medicine, University of Wisconsin Medical School

11. Private Dining Room 508: CARDIAC ARRHYTHMIAS: Francis F. Rosenbaum, M. D., assistant clinical professor of medicine, Marquette University School of Medicine

12. Private Dining Room 509: DIABETES MELLITUS: Bruno J. Peters, M. D., clinical instructor in medicine, Marquette University School of Medicine

*13. Committee Room: UTERINE SURGERY: Paul Doege, M. D., Marshfield

14. Pine Room: THE MANAGEMENT OF ALCOHOLISM: Fritz Kant, M. D., professor of neurology and psychiatry, University of Wisconsin Medical School

*15. Pere Marquette Room: BACK ACHE: Robert E. Burns, M. D., professor of orthopedic surgery, University of Wisconsin Medical School

SPECIAL LUNCHEON—FIFTH FLOOR

16. Ballroom: COMMON ADMINISTRATIVE AND PERSONAL TAX PROBLEMS CONFRONTING PHYSICIANS: Mr. Robert Murphy, Madison, legal counsel of the SMS and Mr. Alfred Granum, Amery, insurance specialist.

General Program, Wednesday, Oct. 4

9:00–10:15 a. m.: SPECIAL TEACHING DEMONSTRATIONS (See pages 798–799 for details)

OB Manikin Demonstration:
Fractures and Application of Casts
Blood Transfusions of Children
Pathologic Clinic

Anatomy Dissections
X-Ray Interpretations
Anesthesia Demonstrations
The Artificial Kidney

10:20–11:50 a. m.: GENERAL ASSEMBLY—PLANKINTON HALL, MILWAUKEE AUDITORIUM

JOSEPH GALE, M. D.
Chairman

10:20 a. m.: THE SPECIAL PROBLEMS OF THE ADOLESCENT CHILD: Joseph A. Johnston, M. D., pediatrician-in-chief, Henry Ford Hospital, Detroit

10:50 a. m.: THE LIMITATIONS AND POSSIBILITIES OF ROENTGEN DIAGNOSIS: Leo Rigler, M. D., professor of radiology and chief of the department of radiology, University of Minnesota Medical School, Minneapolis

11:20 a. m.: MANAGEMENT OF TUMORS OF THE FACE, MOUTH AND JAWS: J. Barrett Brown, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis

LEO RIGLER, M. D.
Minneapolis

J. BARRETT BROWN, M. D.
St. Louis

JOSEPH JOHNSTON, M. D.
Detroit

SEE NEXT PAGE FOR WEDNESDAY NOON ROUND-TABLE LUNCHEONS

SCHEDULE OF FILM SHOWINGS FOR WEDNESDAY

a. m.	
9:00– 9:45	An Improved Technic for the Operative Treatment of Common Anorectal Lesions
9:45–10:25	Breast Cancer: The Problem of Early Diagnosis
10:25–10:55	Esophagogastrostomy for Achalasia of the Esophagus
10:55–11:15	Preface to a Life
11:15–11:40	Surgical Treatment of Hirschsprung's Disease

COMPLETE MOTION PICTURE SCHEDULE ON PAGE 814

SCIENTIFIC

ROUND-TABLE ★ LUNCHEONS

Note: Attendance at luncheons is limited, so advance reservations are desirable. In making your reservation please specify three choices for each of the days you will attend, giving your selection in order of preference. Cost of luncheons: $2.00 each, including gratuities.

WEDNESDAY ★ HOTEL SCHROEDER ★ OCTOBER 4

FOURTH FLOOR MEETING ROOMS

1. Parlor A: MANAGEMENT OF COMPOUND INJURIES OF THE FACE AND JAWS: J. Barrett Brown, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis

2. Parlor B: MENINGITIS: Yale Kneeland, M. D., associate professor of medicine, Columbia University, New York City

*3. Parlor C: THE SELYE ALARM REACTION IN CLINICAL MEDICINE: Jerome W. Conn, M. D., associate professor of internal medicine, University of Michigan Medical School, Ann Arbor

*4. Parlor D: WATER AND ELECTROLYTE BALANCE: Daniel C. Darrow, M. D., professor of pediatrics, Yale University School of Medicine, New Haven, Conn.

*5. Parlor E: CHRONIC INTESTINAL INDIGESTION: Joseph A. Johnston, M. D., pediatrician-in-chief, Henry Ford Hospital, Detroit

6. Parlor F: IRRADIATION THERAPY OF PELVIC NEOPLASMS: H. Dabney Kerr, M. D., professor of radiology, University of Iowa College of Medicine, Iowa City

7. Parlor G: PROBLEMS IN PEDIATRIC SURGERY: P. F. Hausmann, M. D., clinical instructor in surgery, Marquette University School of Medicine

8. Parlor H: WHAT'S NEW IN POISONS?: Elston L. Belknap, M. D., associate clinical professor of medicine, Marquette University School of Medicine

*9. Parlor I: EMOTIONAL DEVELOPMENT IN CHILDREN: H. Kent Tenney, Jr., M. D., associate professor of pediatrics, University of Wisconsin Medical School

* Luncheon filled—no more reservations available!

FIFTH FLOOR MEETING ROOMS

10. Private Dining Room 507: MASS SURVEY ROENTGEN EXAMINATIONS: Leo Rigler, M. D., professor of radiology, University of Minnesota Medical School

*11. Private Dining Room 508: ULCERATIVE COLITIS: Richard Cattell, M.D., Lahey Clinic, Boston

12. Private Dining Room 509: AIDS TO RURAL PRACTITIONERS IN THE RECOGNITION OF EARLY CANCER (Including Biopsy and Other Techniques): W. D. Stovall, M. D., professor of hygiene, University of Wisconsin Medical School and director of State Laboratory of Hygiene; and A. R. Curreri, M. D., associate professor of surgery, University of Wisconsin Medical School

13. Committee Room: THE MATERNAL MORTALITY COMMITTEE—ITS APPLICATION BY LOCAL AND STATE SOCIETIES: Charles W. Mueller, M. D., Kings County Hospital, Brooklyn, N. Y.

*14. Pine Room: PAINFUL SHOULDERS: Herman Schumm, M. D., associate clinical professor of orthopedic surgery and director of department of orthopedic surgery, Marquette University School of Medicine

15. Pere Marquette Room: OBSERVATIONS ON THE PATHOLOGY OF FIBROCYSTIC LESIONS OF BONE: G. A. Bennett, M. D., professor of pathology, University of Illinois College of Medicine, Chicago

Note: After luncheon the Wisconsin Society of Pathologists will meet, but luncheon for general practitioners as well as pathologists.

SPECIAL LUNCHEON—FIFTH FLOOR

16. East Room: EENT Luncheon. Special luncheon for all those attending Section meeting. Informal discussion of EENT problems following luncheon and preceding afternoon scientific program. *All EENT members please register for this luncheon.*

Special Feature

for

ANNUAL DINNER

Hotel Schroeder *Tuesday, Oct. 3*

ALFRED EDWARDS

Due to illness Mr. Cecil Palmer, England, was forced to cancel his engagement as our Annual Dinner speaker, but we have been fortunate to secure as an alternate Alfred Edwards, former member of Parliament and active in the Labour Party until he was expelled because of his continued opposition to the current policies of nationalization. His close contact with the "inner workings" of the dominant political party in England places him in a position to evaluate the program carried on to date.

SPEAKS ON

"THE THROTTLING EFFECTS OF SOCIALISM"

★

Added Feature of Dinner

The following members will be "initiated" into the 50 Year Club:

G. R. BAKER, Tomahawk
L. E. FAZEN, Racine
H. H. KLEINPELL, Prairie du Chien
W. N. LINN, Oshkosh
F. G. PEEHN, Sturtevant
J. F. SMITH, Wausau
HART BEYER, Pittsville
F. P. FOLEY, Dorchester
A. W. LADEWIG, Milwaukee
J. V. MAY, Marinette
E. T. RATHERT, Chilton
S. M. B. SMITH, Wausau
G. A. COOPER, Colfax
J. A. JUNCK, Sheboygan
C. W. LEONARD, Fond du Lac
L. A. MOORE, Monroe
FELIX SCHMIT, Wauwatosa
I. F. THOMPSON, Beloit
DONALD WATERS, Wisconsin Rapids
D. E. W. WENSTRAND, Milwaukee

SECTION MEETINGS—WEDNESDAY, OCT. 4

INTERNAL MEDICINE—PLANKINTON HALL, AUDITORIUM

V. F. LANG, M. D., Milwaukee, Chairman

2:30 p. m.: RECENT ADVANCES IN THE USE OF BAL: Elston L. Belknap, M. D., associate clinical professor of medicine, Marquette University School of Medicine

2:50 p. m.: BACTERIAL AND NON-BACTERIAL INFECTIONS OF THE RESPIRATORY TRACT: Yale Kneeland, Jr., M. D., associate professor of medicine, Columbia University, New York City

3:20 p. m.: RECESS (10 minutes)

3:30 p. m.: RECENT ADVANCES IN VIRUS AND RICKETTSIAL DISEASES: W. D. Sutliff, M. D., Chief, Infectious Disease Section, Veterans Hospital, Memphis, Tenn.

4:00 p. m.: CLINICAL IMPLICATIONS OF ACTH AND CORTISONE: Jerome W. Conn, professor of internal medicine, University of Michigan Medical School, Ann Arbor

OBSTETRICS & GYNECOLOGY—JUNEAU HALL, AUDITORIUM

J. F. EGAN, M. D., La Crosse, Chairman

2:30 p. m.: THE SURGICAL MANAGEMENT OF UTERINE PROLAPSE: B. E. Urdan, M. D., associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine

2:50 p. m.: ADVANCES IN THE TREATMENT OF CARCINOMA OF THE CERVIX, AND EVALUATION OF THE SURGICAL MANAGEMENT: Michael J. Jordan, M. D., associate professor of clinical obstetrics and gynecology, New York University College of Medicine

(Lecture sponsored by Wisconsin Division, American Cancer Society)

3:20 p. m.: RECESS (10 minutes)

3:30 p. m.: THE OBSTETRICIAN'S RESPONSIBILITY IN THE PROBLEM OF PREMATURITY: John W. Harris, M. D., professor of obstetrics and gynecology, University of Wisconsin Medical School

3:50 p. m.: CHORIONEPITHELIOMA OF THE UTERUS: Charles W. Mueller, M.D., Kings County Hospital, Brooklyn

OPHTHALMOLOGY & OTOLARYNGOLOGY—

LUNCHEON AND MEETING IN EAST ROOM, HOTEL SCHROEDER

EDWARD J. ZEISS, M. D., Appleton, Chairman

2:00 p. m.: RETINAL DETACHMENT: William F. Hughes, M. D., professor and head of the department of ophthalmology, University of Illinois College of Medicine, Chicago

2:30 p. m.: ACOUSTIC TRAUMA: Meyer S. Fox, M. D., Milwaukee

2:50 p. m.: OCULAR SARCOIDOSIS: Austin G. Dunn, M. D., Stevens Point

3:10 p. m.: PRACTICAL APPROACHES TO OTOLARYNGOLOGY: Francis L. Lederer, M. D., professor and head of the department of otolaryngology, University of Illinois College of Medicine, Chicago

SECTION PROGRAMS—WEDNESDAY AFTERNOON (Continued)

PEDIATRICS—KILBOURN HALL, AUDITORIUM

K. B. McDONOUGH, M. D., Madison, Chairman

2:30 p. m.: DIAGNOSIS AND TREATMENT OF FIBROCYSTIC DISEASES OF THE PANCREAS: John E. Gonce, Jr., M. D., professor of pediatrics, University of Wisconsin Medical School

2:50 p. m.: THE TREATMENT OF DISTURBANCES IN WATER AND ELECTOLYTES IN INFANTILE DIARRHEA: Daniel C. Darrow, M. D., professor of pediatrics, Yale University School of Medicine, New Haven, Conn.

3:20 p. m.: RECESS (10 minutes)

3:30 p. m.: PROBLEMS IN PEDIATRIC SURGERY: Arthur A. Schaefer, M. D., associate clinical professor of surgery, Marquette University School of Medicine

3:50 p. m.: THE FACTORS WHICH AFFECT GROWTH AS MEASURED BY NITROGEN AND CALCIUM STUDIES: Joseph A. Johnston, M. D., pediatrician-in-chief, Henry Ford Hospital, Detroit

RADIOLOGY—WALKER HALL, AUDITORIUM

H. H. WRIGHT, M. D., Milwaukee, Chairman

2:30 p. m.: THE PHYSIOLOGIC AND ANATOMIC BASIS FOR ROENTGEN DIAGNOSIS OF PULMONARY DISEASE: Leo Rigler, M. D., professor of radiology and chief of the department of radiology, University of Minnesota Medical School, Minneapolis

3:00 p. m.: RADIATION THERAPY OF INTRACRANIAL NEOPLASMS: H. Dabney Kerr, M. D., professor of radiology, University of Iowa College of Medicine, Iowa City

3:30–4:15 p. m.: Case Studies of Special Radiologic Interest

3:30 p. m.: SOME EXPERIENCES WITH NEO-IOPAX IN EXCRETORY UROGRAPHY: H. W. Hefke, M. D., associate clinical professor of radiology, Marquette University School of Medicine, and J. L. Armbruster, M. D., assistant clinical professor of radiology, Marquette University School of Medicine

3:45 p. m.: A CASE OF LYMPHOBLASTOMA WITH UNUSUAL SKIN TUMEFACTIONS: E. A. Pohle, M. D., professor of radiology, University of Wisconsin Medical School

4:00 p. m.: A NEW CLINICO-ROENTGENOLOGIC CLASSIFICATION OF CONGENITAL HEART DISEASE: J. L. Marks, M. D., clinical instructor of radiology, Marquette University School of Medicine

4:15 p. m.: Business meeting and election of officers

SURGERY—ENGELMANN HALL, AUDITORIUM

FORRESTER RAINE, M. D., Milwaukee, Chairman

2:30 p. m.: THE SURGICAL MANAGEMENT OF CARCINOMA OF THE COLON: Frank D. Weeks, M. D., Ashland

2:50 p. m.: SURGICAL REPAIR OF RADIATION LESIONS, INCLUDING THOSE OF ATOMIC ORIGIN: J. Barrett Brown, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis, Mo.

3:20 p. m.: SUBTOTAL GASTERECTOMY IN THE TREATMENT OF PEPTIC ULCERS: W. B. Gnagi, Jr., M. D., Monroe

3:50 p. m.: PRESENT STATUS OF SURGERY OF THE PANCREAS: Richard B. Cattell, M. D., Lahey Clinic, Boston

4:20 p. m.: Discussion of the papers presented

T. O. NUZUM

Scientific Exhibits

PREPARED BY T. O. NUZUM, M.D., JANESVILLE, MEMBER, COUNCIL ON SCIENTIFIC WORK

The Scientific Exhibits for the 1950 Annual Meeting are located at the north end of the arena of the Milwaukee Auditorium. Time will be allowed in the program schedule each day to permit the viewing of scientific and technical exhibits.

S–7a USE OF RADIOACTIVE IODINE IN THYROID DISEASE

Department of medicine, University of Wisconsin Medical School

(E. S. Gordon, M.D. and Edwin Albright, M.D., in charge of the exhibit)

X-ray plates in cancer of the thyroid will show the condition before and after treatment with radioactive iodine. Histologic sections of the same lesions will be shown as well as histologic sections of the thyroid gland after treatment of thyrotoxicosis with radioactive iodine. Numerous charts will show the use of radioactive iodine in both diagnosis and therapy, and a Geiger counter with radioactive iodine will be attended by an assistant, so that visitors will be able to see the apparatus in use. By this means, it is hoped to give a complete picture of this new therapeutic tool in thyroid disease.

S–8 ELECTROENCEPHALOGRAPHY

Marquette University School of Medicine and Veterans Hospital, Wood

(Exhibit under direction of Francis J. Millen, M.D. and Edward D. Schwade, M.D.)

The exhibit will first feature a briefly worded description of the pertinent facts concerning the field of electroencephalography by means of placards, to orient the general practitioner and other medical men in the specialties with this relatively new form of electrodiagnosis. Illustrations will include brief historical facts, technics, indications for the electroencephalogram, and a number of other pertinent data. Included also will be about 50 to 100 parts of actual electroencephalograms to demonstrate its many uses. There may also be available an electroencephalographic recording apparatus for demonstration purposes.

S–9 MILWAUKEE'S BLOOD SERVICE PROGRAM

Junior League Blood Center, Milwaukee

(Tibor Greenwalt, M.D., medical director, in charge of the exhibit)

The exhibit will be a statistical report of the activities of the blood center and will describe the replacement program, the donor club organization, the Maternity Care Insurance Policy, and the Rh diagnostic service. The various products supplied will be mentioned. The newer and more reliable methods of cross-matching will be stressed.

S–10 S–11 HOW A LOCAL HEALTH DEPARTMENT CAN FACILITATE THE SCIENTIFIC PRACTICE OF MEDICINE

Wisconsin State Board of Health

The scientific practice of medicine is facilitated by the seven basic functions of the local health department. Animated charts, photo murals, and colored slides show the value derived by the practicing physician from the following services: *Vital Statistics* of local origin reveal present and pending local health problems; *Health Education* motivates regular visits to the physician; *Laboratory Facilities* close at hand furnish fast confirmation of diagnoses; *Environmental Sanitation* in local areas helps eliminate typhoid and gastroenteritis; *Maternal and Child Health* classes and visits encourage prenatal and postnatal care for each mother by her physician; *Communicable Disease Control* promotes immunization in the general practitioner's office; *Geriatric Service* urges regular medical examinations to detect early degenerative diseases past middle life.

S–12 RHEUMATIC DISEASES

Wisconsin Rheumatism Association

(Mark W. Garry, chief of medical service, Veterans Hospital, Wood, in charge of the exhibit)

I. Reflex Dystrophy of the Upper Extremity: Reflex dystrophy of the upper extremity repre-

sents an effect of, rather than a cause for, disease. A variety of etiologic factors may precipitate the syndrome. Charts, models, and clinical photographs will be presented to delineate a working hypothesis useful in explaining the mechanics of the disorder and to show the form of treatment employed in cervical intraforaminal disease, Sudeck's atrophy, postinfarctional and posthemiplegic syndromes, causalgia, etc.

II. Orthopedic Medical Management of Arthritis: The exhibit will demonstrate photographs of typical deformities, diagrams explaining development of deformities, and models showing treatment, changing treatment, and preventive measures used against usual anticipated complications.

S–13 SOME NUTRITIONAL STUDIES IN TUBERCULOSIS IN ADOLESCENT GIRLS

Joseph A. Johnston, M.D., pediatrician-in-chief, Henry Ford Hospital, Detroit

A series of nutritional studies on adolescent girls with tuberculosis, using the nitrogen and calcium balances, is presented. Separate studies on the factors affecting the balances are presented. Correlations are demonstrated between healing and positive storages, on the one hand, and spread and failure to store, on the other.

S–14 CARCINOMA OF THE CERVIX

Paul F. Doege, M.D., Marshfield

The exhibit will include a classification of the types of carcinoma of the cervix with special emphasis on the minimal histologic changes in the epithelium which cause one to suspect cancer and eventually prove its presence. The entire exhibit is delivered in the form of a short lecture which is projected in full color, the slides being synchronized with a recorded explanation of the material presented. The exhibit will be so arranged that a complete story will be retold every ten minutes throughout the day.

S–15 SIGNIFICANT RADIOLOGIC STUDIES

S–16 Wisconsin Radiologic Society

S–17

(Exhibit under the direction of R. W. Byrne, M.D.)

The exhibit will consist of individual visual discussions of the following topics: "Asymptomatic Pulmonary Lesion," by Dr. Lester Paul, Madison; "X-Ray Aspects of Gastrointestinal Tract Bleeding," by Drs. S. A. Morton and R. W. Byrne, Milwaukee; "Early Bronchogenic Carcinoma," by Dr. T. J. Pfeffer, Milwaukee; "Routine Roentgen Pelvimetry," by Drs. A. Mclamed and A. Marck, Milwaukee; "A Method of Small Bowel Study: Segmental Examination with a Double Lumen Tube," by Dr. J. L. Marks, Milwaukee; "Congenital Dysplasia of the Acetabulum or Congenital Dislocation of the Hip," by Dr. E. Pitts, Racine; and a discussion by Dr. C. E. Schmidt, Milwaukee, whose subject has not yet been announced.

S–18 APPENDICITIS

S–19 Jackson Clinic, Madison

(Exhibit under the direction of George P. Schwei, M.D., Arnold S. Jackson, M.D., and John R. Steeper, M.D.)

This exhibit, consisting of moulages, kodachrome pictures, and charts, will demonstrate the end results of a study of over 4,000 cases of appendicitis observed at the Jackson Clinic during the years 1922 to 1950. Included in the exhibit are a tabulation of the important diagnostic signs and symptoms; moulages demonstrating the steps in the surgical technic; kodachromes of gross specimens with accompanying case histories and postoperative results. A special study of 25 cases of perforated appendices with peritonitis, treated by appendectomy without surgical drainage, chemotherapy, antibiotics, and early ambulation is presented. Charts showing the decrease in morbidity and mortality in the United States and Wisconsin are emphasized.

S–19A DISEASES OF THE VEINS

James M. Sullivan, M.D., Robert Frisch, M.D., and Ray Piaskoski, M.D., Milwaukee

The exhibit will be divided into two sections. One section will depict diagnostic measures used for varicose veins together with charts illustrating various tests. The treatment of varicose veins by stripping will be illustrated by photographs, presentation of instruments, etc. Comparison of the results from the stripping operation with previous methods of treatment will be given.

The second portion of the exhibit will concern itself with thrombophlebitis. Diagnosis will be illustrated by photographs of venograms and the illustration of other diagnostic procedures. The treatment of thrombophlebitis will be considered from both the surgical angle and the medical angle. Ligations and sympathectomy will be compared with anticoagulant therapy.

S–20 PROTRUDED INTERVERTEBRAL DISK

Henry M. Suckle, M.D., Madison, and Madison General Hospital

The signs, symptoms, diagnosis, and treatment of protruded intervertebral disks will be presented. The location and radiation of pain in the spine and in the extremities, concomitant scoliosis, weakness, atrophy, and reflex changes will be outlined. The location of the disk protrusions and their relative frequency in the cervical and lumbar regions will be noted. The physiologic basis of the signs and symptoms dependent on specific nerve root compression will be explained. The value of routine spine x-rays and myelography will be defined and representative roentgenograms will be exhibited. The basis for diagnosis dependent on the symptoms, signs, and roentgen examination will be presented. The conservative treatment and the surgical procedures for the removal of protruded intervertebral disks will be depicted with illustrations.

S–21 HEMANGIOMA

Wayne B. Slaughter, M.D., and Associates, University of Wisconsin Medical School

This exhibit will consist of 300 cases of mixed type hemangiomas treated by various methods. These include x-ray, carbon dioxide, cautery and sclerosing agents. The pathology present and the response are shown on photomicrographs. The conclusions are that sclerosing agents are superior because of little or no damage to overlying skin and no interference with growth centers.

S–22 THE DIAGNOSIS AND TREATMENT OF HERNIATED INTERVERTEBRAL DISKS IN THE CERVICAL, THORACIC, LUMBAR AND LUMBOSACRAL REGIONS

David Cleveland, M.D., and E. J. Kiefer, M.D., Milwaukee, in cooperation with Veterans Administration Hospital, Wood

The exhibit will be made up of x-rays showing the various lesions, as demonstrated by myelographic study, and also x-rays of the spine in the various regions, showing pathology occasionally seen with intervertebral disks. There will be photographs of patients preoperatively and postoperatively; photographs of the specimens removed at operation and charts illustrating methods of diagnosis, based on subjective and objective findings and pictures illustrating operative findings.

S–23 DISEASES OF THE THORAX

Departments of surgery, pathology, medicine, and radiology, University of Wisconsin Medical School

(Joseph W. Gale, M.D., professor of surgery, in charge of the exhibit)

This exhibit consists of a clinical and pathologic study of diseases of the thorax. Kodachrome photographs showing gross and microscopic specimens along with a clinical history of each case are shown. The exhibit includes new growths of the lung and mediastinum, inflammatory diseases of the lung. Other studies included in the exhibit are bronchial adenoma, carcinoma and mediastinal tumors. One especially interesting case of adenomatosis and two cases of coccidioidomycosis of the lung are included.

S–24 CANCER OF THE BREAST

S–25

(A. R. Curreri, M.D., associate professor of surgery, in charge of this portion of the exhibit)

CANCER OF THE RECTUM

(E. R. Schmidt, M.D., professor of surgery, in charge of this portion of the exhibit)

Department of surgery, University of Wisconsin Medical School

The part of the exhibit demonstrating cancer of the breast will emphasize the statistical, early diagnostic, and treatment phases. Methods of breast examination, findings in early cancer, indications for biopsy and surgical treatment, and end results from treatment will be illustrated.

The portion of the exhibit which concerns itself with carcinoma of the rectum will demonstrate briefly the present statistical survival rate as compared to possible optimum survival rates. Methods of diagnosis, including history, physical, rectal, and proctoscopic examinations, will be shown by color transparencies. Furthermore, the various types of lesions seen in the rectum and sigmoid will be presented.

S–26A *APPLICATION OF CASTS

S–33A

(Exhibit and demonstration presented by the Wisconsin Society of Orthopedic Surgery)

This exhibit and demonstration will be one of 8 featured teaching programs carried on each morning from 9:00–10:20 a.m., and also during the afternoon recess period. Various types of casts will be applied by Wisconsin orthopedists, serving as teachers and demonstrators.

S–26 *THE NERVES TO THE VISCERA AND THE

S–27 SURGICAL APPROACHES TO PARTS OF THE AUTONOMIC NERVOUS SYSTEM

Department of anatomy, University of Wisconsin Medical School

(Exhibit in charge of Frederick D. Geist, M.D. and Otto Mortensen, M.D.)

The exhibit and demonstration will present a dissection of the nerves in the neck, thorax, abdomen, and pelvis in one specimen. In another subject the demonstrators will show the surgical approaches to, and exposure of, certain of the nerves.

This scientific exhibit will be one of 8 demonstrations every morning from 9:00–10:20, at which time special lectures will be held.

S–28 *SPINAL ANESTHESIA

S–29 *THE FUNCTION OF RESPIRATION

Department of anesthesiology, University of Wisconsin Medical School

(The exhibit and demonstration will be under direction of Simpson S. Burke, M.D., assistant professor of anesthesia)

The exhibit will consist of two demonstrations, probably to be staged alternately. The first demonstration is the hydrodynamics of spinal anesthesia. A short, simple demonstration of some of the elementary factors affecting the administration of spinal anesthetics will be presented. The presentation will take 15–20 minutes. It is intended to show as simply as possible some of the effects of common procedures and ordinary errors of technic. The other demonstration will show with a plastic mechanical model various aspects of the function of respiration showing alterations in pressures and air exchange under conditions which ordinarily have adverse effects on the respiration of patients.

This scientific exhibit will be one of 8 demonstrations every morning from 9:00–10:20, as well as during the afternoon recess period.

S–30 DIABETES MELLITUS

S–31 Marquette University School of Medicine, United States Public Health Service, and Veterans Hospital, Wood

(Exhibit under the direction of Bruno J. Peters, M.D., J. M. Meyer, M.D. and Maurice Hardgrove, M.D.)

This exhibit is to be a statistical summary of the diabetic survey being conducted in Milwaukee. The survey at present is under the direction of the Medical Society of Milwaukee County, United States Public Health Service, and the Milwaukee Health Department. The procedures being used in conducting this survey will be displayed; the number of patients tested to date together with the number of proved cases will be summarized on charts. In addition, there will be a display which is to cover the treatment of diabetic coma and the use of insulin mixtures in the control of diabetes.

* Denotes that this exhibit will feature special demonstrations each morning from 9:00–10:20 a.m., as well as during the afternoon recess.

H. K. TENNEY

Motion Picture Schedule

FILMS SELECTED BY H. K. TENNEY, JR., M. D., MADISON, BY REQUEST OF COUNCIL ON SCIENTIFIC WORK

THE SURGICAL TREATMENT OF HIRSCHSPRUNG'S DISEASE (Congenital Achalasia of the Terminal Gut): Sound, color, 15 minutes.

This film shows a new surgical approach to the problem of treatment of Hirschsprung's disease. Nothing is said concerning the preoperative and postoperative care of such patients or of the end result. Pertinent points are well described.

WHEN SHOWN: Monday, Oct. 2: 4:00-4:25 p.m. Tues., Oct. 3: 3:05-3:30 p.m. Wed., Oct. 4: 11:15-11:40 a.m.

ON OUR OWN: Sound, black and white, 14 minutes.

The latest steps in the rehabilitation of patients with advanced poliomyelitis as practiced at the New York Rehabilitation Institute are shown. Many of the ideas first introduced at the Institute for the Crippled and Disabled in New York City are now followed in this program.

WHEN SHOWN: Monday, Oct. 2: 4:00-4:25 p.m. Tues., Oct. 3: 2:30-2:45 p.m.

INTERNAL WIRE FIXATION OF FRACTURES OF THE JAW: Silent, color, 20 minutes.

This film shows a method of drilling a wire across the fragments of various types of fractures of the jaw which obviates the use of complicated dental and plaster splints.

WHEN SHOWN: Tues., Oct. 3: 9:00-9:20 a.m.

ESOPHAGOGASTROSTOMY FOR ACHALASIA OF THE ESOPHAGUS: Sound, color, 24 minutes.

Briefly shown are the indications for surgical intervention in the treatment of achalasia of the esophagus, demonstrating diagrammatically the purpose of the operation. It proceeds quickly to the actual surgery in the case depicted. The left lobe of the liver is elevated and the distal esophagus is mobilized to obtain adequate exposure. It demonstrates the development of the consecutive steps in the construction of the new opening between the lateral aspect of the distal esophagus and the fundus of the stomach.

WHEN SHOWN: Tues., Oct. 3: 9:45-10:15 a.m. Wed., Oct. 4: 10:25-10:55 a.m.

AN IMPROVED TECHNIC FOR THE OPERATIVE TREATMENT OF COMMON ANORECTAL LESIONS: Silent, color, 45 minutes.

The film presents the principles of physical diagnosis in anorectal inflammatory disease, the underlying pathogenesis and the proper surgical management of these conditions, especially the more common ones such as hemorrhoids, anal fissures, anal abscesses, and fistulas.

WHEN SHOWN: Monday, Oct. 2: 2:45-3:30 p.m. Tues., Oct. 3: 10:45-11:30 a.m. Wed., Oct. 4: 9:00-9:45 a.m.

A DAY IN THE LIFE OF A CEREBRAL PALSIED CHILD: Sound, color, 30 minutes.

This film depicts the activities and problems of a boy with cerebral palsy; problems of dressing, eating, standing, walking, talking, writing, and undressing are taken up in turn. Emphasis is placed on the application of the methods of physical medicine and occupational therapy in cerebral palsy.

WHEN SHOWN: Tuesday, Oct. 3: 9:20-9:45 a.m.

PREFACE TO A LIFE: Sound, 30 minutes.

Available from the State Board of Health, Madison 2.

The life of an average American boy and the effect of three different parental attitudes toward him are illustrated. The film shows that when his parents help the boy to develop according to his own capabilities, he grows up into a man capable of living a satisfying, productive life. The opposite is shown when each parent tries to force him to become the kind of man each wishes him to be. He is then unable to meet their demands and grows up a restless, dissatisfied person.

WHEN SHOWN: Tuesday, Oct. 3: 2:45-3:05 p.m. Wed., Oct. 4: 10:55-11:15 a.m.

[FOR ADDITIONAL FILMS SEE NEXT PAGE]

PAY ATTENTION: Sound, 30 minutes.

Available from the State Board of Health, Madison 2.

This film shows some of the educational and personality problems faced by the child who is hard of hearing but is not "deaf" and suggests some of the ways in which parents, teachers, and specialists can help. Understanding of the problem and its early treatment, the use of "context" methods of speech reading, and the early use of hearing aids where appropriate are stressed.

WHEN SHOWN: Monday, Oct. 2: 3:30-4:00 p.m. Tues., Oct. 3: 10:15-10:45 a.m.

BREAST CANCER: THE PROBLEM OF EARLY DIAGNOSIS: Sound, color, 34 minutes.

Available from the State Board of Health, Madison 2.

The picture effectively demonstrates the parts played by "physician suspicion," careful examination, and reliance on surgical biopsy in arriving at an early specific diagnosis. The statistics of mammary cancer are discussed in a manner adequate to make the average physician conscious of the fact that early cancer of the breast is clinically indistinguishable from a benign lesion.

WHEN SHOWN: Monday, Oct. 2: 4:25-5:00 p.m. Tues., Oct. 3: 3:30-4:10 p.m. Wed., Oct. 4: 9:45-10:25 a.m.

Daily Schedule of Film Showings

MONDAY

p. m.

2:30– 2:45	On Our Own
2:45– 3:30	An Improved Technic for the Operative Treatment of Common Anorectal Lesions
3:30– 4:00	Pay Attention
4:00– 4:25	Surgical Treatment of Hirschsprung's Disease
4:25– 5:00	Breast Cancer: The Problem of Early Diagnosis

★

TUESDAY

a. m.

9:00– 9:20	Internal Wire Fixation of Fractures of the Jaw
9:20– 9:45	A Day in the Life of a Cerebral Palsied Child
9:45–10:15	Esophagogastrostomy for Achalasia of the Esophagus
10:15–10:45	Pay Attention
10:45–11:30	An Improved Technic for the Operative Treatment of Common Anorectal Lesions

p. m.

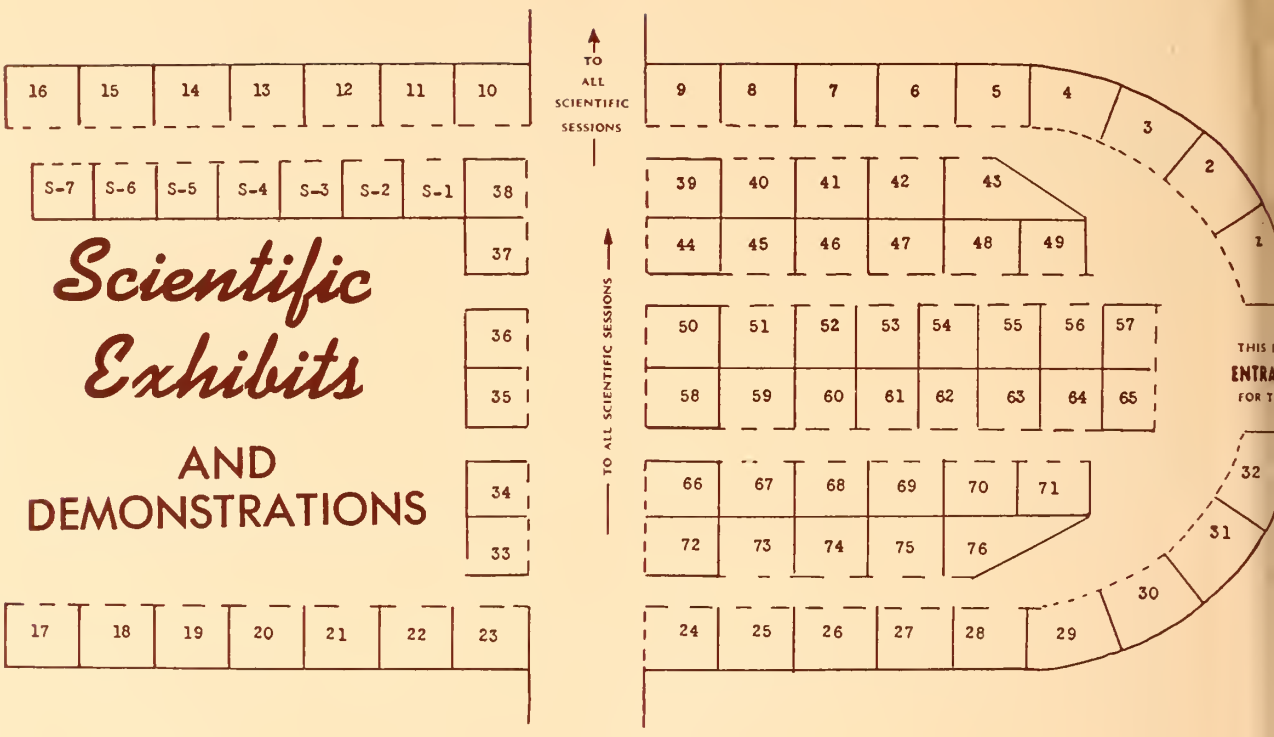
2:30– 2:45	On Our Own
2:45– 3:05	Preface to a Life
3:05– 3:30	Surgical Treatment of Hirschsprung's Disease
3:30– 4:10	Breast Cancer: The Problem of Early Diagnosis

★

WEDNESDAY

a. m.

9:00– 9:45	An Improved Technic for the Operative Treatment of Common Anorectal Lesions
9:45–10:25	Breast Cancer: The Problem of Early Diagnosis
10:25–10:55	Esophagogastrostomy for Achalasia of the Esophagus
10:55–11:15	Preface to a Life
11:15–11:40	Surgical Treatment of Hirschsprung's Disease



TECHNICAL EXHIBITS

Booth	COMPANY AND PRODUCTS

37 Abbott Laboratories, North Chicago, Ill.

The Abbott exhibit will include *Sucaryl Sodium*, a new non-calorie sweetening agent that withstands cooking, baking, and canning; *Nembutal*, a short acting barbiturate with a wide range of uses; *Pentothal Sodium*, an anesthetic for intravenous use; and various penicillin and vitamin products.

51 A. S. Aloe Company, St. Louis

Your Aloe representative will be happy to welcome you at booth 51. He has on display a representative cross-section of the surgical and laboratory equipment and supplies stocked by the "world's largest surgical supply house." Featured are many new items which you will want to see and have demonstrated.

73 American Hospital Supply Corporation, Evanston, Ill.

Baxter Intravenous Solutions and *Transfusion Equipment* with all necessary disposable accessories; high titered blood-typing serums; Tomac Oral Protein Supplement—a remarkably palatable, nonhydrolyzed powdered protein; the *Staticator* —for detecting and controlling static electricity in the operating room; the Krasno-Ivy Flicker photometer for early detection of heart disease; and a selected group of Tomac specialties will be displayed.

Booth	COMPANY AND PRODUCTS

67 Armour Laboratories, Chicago
68

The Armour Laboratories will welcome members of the State Medical Society of Wisconsin to visit the Armour exhibit, booths 67 and 68, while attending their annual convention.

Information on many new items in the field of endocrinology recently made available to the medical profession by the Armour Laboratories may be secured at the Armour booth.

66 Ayerst, McKenna & Harrison, Ltd., New York

Premarin (estrogenic substances, water-soluble), a highly effective and well tolerated preparation of naturally occurring, orally active, conjugated estrogens (equine) will be featured. The potency of *Premarin* is expressed in terms of its principal estrogen, sodium estrone sulfate. *Premarin* provides convenience of administration and flexibility of dosage. Four potencies of *Premarin* tablets are available. *Premarin* is also presented in liquid form.

75 Baby Development Clinic, Chicago

The Baby Development Clinic will feature infant feeding from the psychologic standpoint. Literature and other visual material for use of patients will be displayed so that copies may be requested for office use. Evenflo Nursing Units and Minute Maid Orange Juice will be a part of this display.

Booth COMPANY AND PRODUCTS

S–7 Baker Laboratories, Inc.

Baker's Modified Milk (Powder and Liquid) is made in Wisconsin from grade A cows' milk and is fortified at seven strategic points to obtain more efficient nutritive action and is adjusted and processed to insure better tolerance. Our representatives will gladly tell you more about this complete, easily prepared, low cost infant food.

32 Barr X-Ray Company, Milwaukee

This is a display of the Wisconsin distributors representing the F. Mattern Manufacturing Company, manufacturers of diagnostic and therapy x-ray equipment.

74 Beech-Nut Packing Company, New York

The Beech–Nut nutritionists will be in attendance at their exhibit to discuss the Strained and Junior Foods. One of the newest products, *Beech–Nut Cereal Food*, will also be on display. It is a scientifically prepared blend of enriched farina, oatmeal, defatted wheat germ, cornmeal, defatted corn germ, powdered beef bone, dried Brewer's yeast, salt and sodium iron pyrophosphate. The nutritionists will also be happy to describe their Nutrition Program.

45 N. P. Benson Optical Company, Minneapolis

Complete lines of ophthalmic and optical supplies will be exhibited. These include the newest in spectacle styling, contact lenses, artificial eyes, etc. We will be happy to discuss lens problems with you and demonstrate the fine Cen-Cor bifocal and trifocal. Completely equipped Wisconsin laboratories are located in the following cities: Eau Claire, La Crosse, Wausau, Beloit, and Stevens Point.

S–13
S–14 House of Bidwell, Milwaukee

This exhibit will feature the individualized services of the House of Bidwell in assisting physicians with the fitting of orthopedic appliances to meet the special needs of their patients. The display will feature the complete line of braces, artificial limbs, trusses and other equipment required in orthopedic work. A new feature will be the Sabel Corrective Shoes, which are now being furnished through the House of Bidwell as exclusive agents for Wisconsin.

38 Borden Company, New York

A new improved better-than-ever *Biolac* is presented in booth 38—better nutritionally and better physically. Unchanged are the dilutions, analysis, caloric values, vitamin fortification, and ease of feeding. This new improved *Biolac*, a liquid modified milk for infant feeding, brings to you the latest findings of nutritional science . . . at no increase in cost. Likewise exhibited will be our long established products for infant feeding: *Dryco*, *Mull–Soy*, Merrell– Soule special milks, general purpose *Klim*, and *Beta Lactose*.

46 Brooks Appliance Company

Doctors will want to visit our booth 46 and inspect the quality bandages which will be on display. We shall feature *Polyestol*, an elastic transparent bandage which when applied releases Methyl Salicylate by absorption into the blood stream at an approximate rate of 3.5 mg. per square inch per hour at normal body temperature. The medicated primer plus *Dalzoflex* Elastic Adhesive may be used to advantage in treating leg ulcers, phlebitis, etc. Mr. Ayer will describe in detail the technic of application. Proctologic instruments, syringes, needles and elastic hosiery will also be displayed.

39 Burroughs Wellcome & Co., Inc., New York

"B. W. & Co." will feature a completely new type antihistaminic, *Perazil* brand chlorcyclizine hydrochloride. *Perazil* differs chemically in that it is a piperazine, rather than a conventional ethylenediamine compound, and a single dose provides 12 to 24 hour action. We will also feature "Wellcome" brand *Globin Insulin*, the accepted intermediate-acting insulin, and *Digoxin*, for safe predictable digitalization.

24 Camel Cigarettes (R. J. Reynolds Tobacco
25 Company), New York

Camel cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking Camel cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking Camels."

18 S. H. Camp and Company, Jackson, Mich.

A complete line of anatomic supports for prenatal, postoperative, orthopedic visceroptosis and hernia conditions will be shown. Experts from the Camp staff will be in attendance to answer questions.

71 Carnation Company, Los Angeles, Calif.

You are invited to visit the Carnation Company booth 71, where you will see an attractive display presenting some interesting information on the various uses of Carnation Vitamin D Evaporated Milk for infant feeding, child feeding, and general diet purposes. The method by which Carnation Milk is generously fortified with vitamin D—400 U.S.P. units per reconstituted quart—will be explained. Valuable literature will also be available for distribution.

60 Chicago Dietetic Supply House, Inc., Chicago

CELLU Dietary Foods, for the starch and sugar restricted, allergy and low sodium diets, are featured in booth 60. *Juice-Pak* fruits, unsalted vegetables, gelatin dessert, low sodium bread and diet scales are only a few of the items displayed. Your visit to our exhibit will be appreciated.

19 Chicago X-Ray Sales Company, Chicago

58 Ciba Pharmaceutical Products, Inc., Summit, N. J.

The Ciba exhibit will feature *Pyribenzamine* in the treatment of drug dermatoses, showing the action of this effective antihistaminic when absorbed through damaged skin and by oral administration.

Representatives in attendance will be glad to answer questions about *Pyribenzamine* and other Ciba products used in dermatology.

Booth COMPANY AND PRODUCTS

31 Coca-Cola Bottling Company, Milwaukee

Booth 31 will be a refreshment stand for Coca-Cola in bottles.

8 Downs X-Ray Company, Milwaukee

Downs X-Ray Company will exhibit the EDIN ink writing electronic cardiograph, also Profex-ray x-ray equipment and x-ray supplies.

17 Encyclopaedia Britannica, Milwaukee

30 H. G. Fischer & Co., Franklin Park, Ill.

At booth 30 inspect H. G. Fischer & Co.'s modern, efficient, low priced x-ray and physical therapy equipment. Let them point out many features of advantage in these representative units and other models not on display and also explain their extremely liberal terms of sale. Your visit welcome—no obligation.

72 C. B. Fleet Co., Inc., Lynchburg, Va.

C. B. Fleet Company, Inc., cordially invites you to stop by booth 72 for a short visit with the representative who sees you in your office about once a year. Perhaps there is something about *Phospho-Soda* (Fleet), the pure, stable aqueous concentrate of the two U.S.P. sodium phosphates, you would like to discuss with him.

1 General Electric X-Ray Division, Milwaukee

The General Electric X-Ray Corporation will exhibit the Maxicon—a revolutionary new idea in x-ray apparatus design. Comprised of a number of components that can be varied in assembly, or added to any unit at any time; it covers the range of diagnostic apparatus from the horizontal Bucky table to the motor-driven combination unit. A selective line of apparatus, it allows x-ray facilities to grow by adding components to a basic unit, a step at a time.

Also shown, the Cardioscribe, portable direct writing electrocardiograph, with many new improvements in design for high fidelity heart recordings; and the model E Inductotherm, a moderately priced high out-put diathermy unit.

40 Gerber Products Company, New York

Is it baby feeding or babying adults' alimentary tracts? Either or both—we can serve you with a *complete* line of good-to-eat Strained and Junior foods plus new editions of baby care booklets. The 1950 Special Diet Recipes is nutritionist-edited for smooth diet simplification and palatability. We are on the exhibit floor to greet you.

S–4 H. J. Heinz Company, Pittsburgh

H. J. Heinz Company, Pittsburgh, will display strained and junior foods as well as a wide variety of nutrition material at booth S–4. Doctors will find the products of interest not only for feeding infants and other small children, but also in gastrointestinal cases, preoperative and postoperative disturbances, oral troubles, geriatrics, and a number of conditions where strained and junior foods are required.

70 Hoffman-La Roche, Inc., Nutley, N. J.

Roche will feature *Gantrisin*, the new sulfonamide which has outstanding therapeutic advantages. *Gantrisin* is distinguished by comparatively high solubility even in neutral and slightly acid solutions. It is not likely to cause crystalluria and it does not require concomitant alkali therapy. *Gantrisin* is highly effective in the treatment of systemic and urinary tract infections.

Why not stop at the Roche booth, where members of the field staff will be in attendance to tell you more about *Gantrisin*, the radically different sulfonamide.

33 Hurley X-Ray Company, Milwaukee
34

Picker x-ray equipment, accessories and Burdick physical therapy units, including the direct writing electrocardiograph, will be shown. We'll also have some comfortable chairs where you can rest and visit with our field men.

55 "Junket" Brand Foods, Little Falls, N. Y.

Essential facts on the chemistry of the rennet enzyme and the nutritional significance and psychologic value of rennet desserts in the diets of infants and adults will be explained. The enzymatic action of rennet in producing softer, finer, more readily-digestible milk curds is illustrated by enlarged photos. Literature giving the dietary applications of rennet products is available for your reference.

20 Karrer Company, Milwaukee
21

Our outside representatives will welcome their friends at booths 20 and 21, where the Karrer Company will display Hamilton, Allison, and Ritter medical furniture, Birtcher and Lieber–Flarsheim short wave and electrosurgical units, ultraviolet and infra-red lamps, portable and cabinet sterilizers, autoclaves, basal metabolors, suction and pressure units, physicians' bags, centrifuges, diagnostic and surgical instruments, B.D. and Vim syringes and needles, and many other new items.

4 Kremers–Urban Company, Milwaukee

A cordial invitation is extended to all physicians to visit the Kremers–Urban Company display. *Estrugenone*, a new form of estrogen therapy for both rapid and prolonged relief of subjective symptoms of the menopause, will be featured. Other Kremers–Urban Council-accepted pharmaceuticals will be on display.

S–2 Laabs, Inc., Milwaukee
S–3

Over fifty years' service to the medical profession has been given by this distributor of physicians, hospital, and industrial medical supplies, pharmaceuticals, laboratory supplies, surgical instruments, and equipment.

22 Lakeside Laboratories, Inc., Milwaukee
23

The Lakeside booth will feature research progress for the past two years in mercurial diuretics. The display involves more than fifty experimental compounds of various types, a program continuing at the present time and in the foreseeable future to synthesize more effective, safe, usable diuretics. This booth will present the latest news in this research field.

Booth COMPANY AND PRODUCTS

64 Langer Laboratories, Inc.

Our pharmaceutical display
Is well worth seeing on your way;
We feature products old and new
And we're on hand to welcome you.
So if there's anything you lack—
Stop in and see Herman or Jack!

69 Lederle Laboratories Division, New York

You are cordially invited to visit our exhibit in booth 69, where you will find representatives who are prepared to give you the latest information on Lederle products.

44 Eli Lilly and Company, Indianapolis, Ind.

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in booth 44. The display for 1950 features a presentation on the incidence and potential number of diabetic persons in America. The attending representatives will be pleased indeed to assist visiting physicians in every way possible.

15 J. B. Lippincott Company, Philadelphia, Pa.

J. B. Lippincott Company presents an interesting and active exhibit of professional publishing. With the "pulse of practice" centering in an advisory editorial board of active clinicians who constantly review the field, current and coming trends in medicine and surgery are known continually. On the studied recommendations of these medical leaders, Lippincott selected professional books are undertaken.

42 Luzier's Inc., Kansas City, Mo.

A complete display of Luzier fine cosmetics and perfumes will be exhibited in booth 42. This will be of interest to dermatologists and allergists as well as to the ladies who visit the convention. Distributors of preparations by Luzier will be on hand to explain Luzier's service in the field of allergy.

35 M & R Dietetic Laboratories, Inc., Columbus Ohio

Our representatives for *Similac* and *Cerevim* will appreciate the opportunity to discuss with you the merits and use of our products in the field of infant and child nutrition.

26 Mead Johnson and Company, Evansville, Ind.

Dextri-Maltose, Oleum Percomorphum, Pablum, Pabena, Olac and other Mead products used in infant nutrition will be on display at the Mead Johnson exhibit at your State Medical Society of Wisconsin meeting. *Protenum*, a new high protein product, will be displayed. Also, *Lonalac*, for low sodium diets. Our representatives at the exhibit will be glad to discuss with you the new improvements of *Amigen* and *Amisets*.

6 Medical Protective Company, Fort Wayne, Ind.

The Medical Protective Company of Fort Wayne, Ind., is represented at booth 6, where you are invited to call. Medical Protective specialized service is an institution of the medical profession whose legal liability problems we have contemplated on for fifty-one years.

Bring your professional liability questions and problems to booth 6.

Booth COMPANY AND PRODUCTS

28 Medico-Mart, Inc., Milwaukee
29

Physician's and hospital furniture, equipment and supplies, diagnostic instruments and equipment, basal metabolism machines, electrocardiographs, electrosurgical equipment, sterilizers and autoclaves, shortwave and microwave machines, surgical and office lights, ultraviolet lamps and therapeutic equipment, general professional supplies and specialties will be displayed.

65 The Wm. S. Merrell Company, Cincinnati

Merrell will feature *Diothane Ointment* with Oxyquinoline Benzoate, an improved preparation for applying an anesthetic to areas that require prolonged contact and where it is desirable to provide a protective antiseptic coating. Of relatively low toxicity, *Diothane Ointment* with Oxyquinoline Benzoate has established a reputation for safety in clinical use.

76 Milwaukee Artificial Limb Company, Milwaukee

This booth will feature a display of artificial limbs, braces, trusses, supporters, elastic hosiery, crutches, and canes.

50 V. Mueller & Company, Chicago

V. Mueller & Company extend a cordial invitation to visit their exhibit in booth 50. A new hydraulic rectal table will be shown in addition to many recent developments in the surgical instrument line.

11 A. R. Nechin Company, Chicago

In booth 11 will be exhibited the Jones *Motor-Basal* and *Multi-Basal*, the original waterless metabolism units. Demonstrations will be made to show how the units automatically correct for barometric and temperature changes. Also on exhibit will be the *Cardiotron*, the pioneer portable direct - recording electrocardiograph which affords new convenience in cardiology combined with the highest degree of scientific accuracy. The minutest heart action is precisely and permanently recorded on standard graph paper the instant it occurs.

27 John Nichols, Inc., Milwaukee

A demonstration of the *Audograph* dictating machine employing a flat plastic disc with a maximum of 1 hour of recording. The disc can be reprocessed and used over up to 50 times.

S-6 Paravox, Inc., Cleveland

The Paravox neon plastic chassis display, one of the most distinctive of its kind, has been used at numerous fairs and conventions throughout the nation and has received much favorable comment. The display shows the manufacturing steps, with parts mounted on a black mirrored surface, in the assembly of Paravox hearing aids. Luminous plastic has been used to mold the chassis parts and hidden neon tubes surround the display panel.

49 Parke, Davis and Company, Detroit

Medical service members of the Parke, Davis and Company staff will be in daily attendance at our commercial exhibit for consultation and discussion of the various products listed in our pharmaceutic, antibiotic, and biologic cata-

Booth COMPANY AND PRODUCTS

log. Important specialties, such as *Chloromycetin, Penicillin S–R, Benadryl*, vitamins, *Oxycel, Thrombin Topical, Influenza Virus Vaccine*, and others will be featured. You are most cordially invited to visit our exhibit with the assurance that your personal interest will indeed be very much appreciated.

12 H. E. Pengelly X-Ray Company, Milwaukee

The H. E. Pengelly X-Ray Company serves as a distributor of medical x-ray equipment, both diagnostic and therapeutic. A complete line of x-ray accessories and supplies will be shown.

48 Pet Milk Company, St. Louis

Specially trained representatives will be in attendance to discuss the use of Pet milk in infant feeding and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

3 Philip Morris & Co., ltd., New York

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

56 Photoart Visual Service, Milwaukee

There will be a general display of photographic equipment used for clinical photography; also, a complete display of visual and audio equipment for personnel training, etc.

62 Physicians and Hospitals Supply Company, Minneapolis

63

It is with a great deal of pleasure that we display our complete line of Ulmer specialties. We hope that you will look over the many new Ulmer products as well as our new Injectible line.

We will also have on display many new and interesting items in the equipment and instrument line, as well as the new Beck–Lee Direct Writing Cardi-All.

16 Professional Business Service, La Crosse

Consultants on managerial and tax problems will be at the booth to greet doctors and explain the services of this organization.

43 Roemer Drug Company, Milwaukee

The House of Quality, covering surgical instruments, office furniture, hospital and laboratory supplies.

52 Sandoz Chemical Works, Inc.

For the non-narcotic relief of migraine, physicians will be interested in *Gynergen* (ergotamine tartrate); also featured are *Digilanid*, a combination of the pure crystalline Lanatosides A, B and C; *Scillaren* and *Scillaren B*, containing the cardiodiuretic principles of squill—all of these cardioactive glycosides are standardized gravimetrically; *Calglucon*, original brand of calcium gluconate for palatable oral calcium therapy; *Sandoptal*, an effective hypnotic and sedative.

Booth COMPANY AND PRODUCTS

57 W. B. Saunders Company, Philadelphia

We invite all doctors attending the meeting of the State Medical Society of Wisconsin to visit our exhibit, where we will display a complete line of our books, including Hyman's "Integrated Practice of Medicine," Bockus' "Postgraduate Gastro-Enterology," Shanks' "Textbook of X-Ray Diagnosis," Anson's "Atlas of Human Anatomy," Friedberg's "Diseases of the Heart," Sunderman and Boerner's "Normal Clinical Values," Wolff's "Electrocardiography," Mitchell and Nelson's "Pediatrics," new (second) edition of Pullen's "Medical Diagnosis," new (sixth) edition of Curtis–Huffman's "Textbook of Gynecology," and many other new books and new editions.

9 Schering Corporation, Bloomfield, N. J.

Buccal Tablets of *Oreton, Progynon, Proluton*, and *Cortate* with the exclusively new base, Polyhydrol, will be featured at the Schering exhibit. Polyhydrol makes possible complete absorption of hormones via the buccal route providing advantages of high effectiveness, convenience, and economy. *Trimeton and Chlor-Trimeton*, two outstanding antihistamines, and *Coricidin*, Schering's new treatment for the common cold, will highlight the exhibit.

Schering representatives will be present to welcome your inquiries concerning other Schering pharmaceutical specialties.

10 G. D. Searle & Company, Chicago

You are cordially invited to visit the Searle booth, where our representatives will be happy to answer any questions regarding Searle products of research. Featured will be *Banthine*, the true anticholinergic drug for the treatment of peptic ulcers; *Dramamine*, for the prevention and active treatment of motion sickness; and *Alidase*, Searle brand of hyaluronidase which permits subcutaneous feedings at intravenous speed. Other time-proven products of Searle research on which information may be obtained are Searle *Aminophyllin* in all dosage forms, *Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine*, and *Pavatrine with Phenobarbital*.

S–1 Sharp & Dohme, Inc., Philadelphia

Visitors are cordially invited to visit the Sharp & Dohme exhibit in booth S–1. Stable, portable *"Lyovac"* normal human plasma irradiated to destroy viral contaminants that might cause homologous serum hepatitis merits your attention. Unusual specialties, including *"Cremo"*-sulfonamides, pleasantly flavored, palatable suspensions of the most effective systemic and enteric sulfonamides, and *Delmor*, a delicious nutrient powder, also will be of major interest.

53 Smith–Dorsey Company, Lincoln, Neb.

Testosterone Propionate, Mercurophyllin and *Dorestro* Ampoules are of special interest in this year's Dorsey exhibit. In addition, *Testosterone Tablets, Aminophylline Suppositories* and many other Council-accepted products are presented for your inspection and discussion. You are welcome to make the Dorsey booth your headquarters during the meetings.

Booth COMPANY AND PRODUCTS

5 Smith, Kline & French Laboratories, Philadelphia

Dexamyl—SKF.'s balanced combination of "Dexedrine" Sulfate (dextroamphetamine sulfate, S.K.F.) and "Amytal" (Amobarital, Lilly)—is a new preparation of wide usefulness in everyday practice. Combined in *Dexamyl*, "Dexedrine" and "Amytal" work together to provide symptomatic relief from mental and emotional distress.

54 E. R. Squibb & Sons, New York

E. R. Squibb and Sons will present an exhibit based on Squibb professional specialties and service material related to those products.

61 The Upjohn Company, Kalamazoo, Mich.

The Upjohn exhibit will feature the anticoagulant family: *Heparin, Depo-Heparin,* and *Dicumarol.* Emphasis will be placed on *Depo-Heparin* (Heparin in gelatin) because of its prolonged effects. A single dose of 1 cc. (200 mg.) of *Depo-Heparin* will prolong the blood coagulation time for about twenty-four hours. Upjohn representatives will be in attendance to discuss with the doctors this interesting improvement in heparin therapy.

41 U. S. Standard Products Co., Woodworth, Wis.

At booth 41 emphasis will be placed on newly developed products. The theme of the exhibit will be "Immunization and Nutrition."

7. U. S. Vitamin Corporation, New York

Exhibit demonstrates the greatest vitamin technicologic advance of the present decade—"oil-in-water" multi-vitamin solutions—includes *Vi-Syneral Injectable,* which makes available for the first time in pharmaceutical history, an aqueous parenteral multi-vitamin solution, ready for immediate injection; also the original oral aqueous multi-vitamin formula, *Vi-Syneral Vitamin Drops*—since 1943.

47 Varick Pharmacal Company, New York

Digitaline Nativelle, chief active principle of digitalis purpurea, is featured in a comprehensive exhibit of the Varick Pharmacal Company of New York. This world-renowned cardiotonic—the first of the digitoxins—has become especially favored because of its more complete absorption and its uniform rate of dissipation which enable it to maintain the maximum efficiency obtainable.

2 White Laboratories, Inc., Newark, N. J.

At this booth will be an interesting display of outstanding new products. Trained medical service representatives in attendance will appreciate the opportunity to discuss with you the clinical background and therapeutic merit of the recent products of White's research. You are cordially invited to visit the booth.

36 Winthrop-Stearns, Inc., New York

Winthrop-Stearns, Inc., New York, extends a cordial invitation to visit booth 36, where representatives will be on hand to discuss the latest therapeutic contributions made by this firm. Featured will be *Aralen,* effective antimalarial, also specific for extra-intestinal (hepatic) amebiasis; *Milibis,* new, virtually nontoxic amebacide; *Isuprel,* efficient and convenient bronchodilator, tablets for sublingual use, solution for inhalation; *Mebaral,* sedative and antiepileptic, produces tranquility without drowsiness.

S-5 Wyeth, Incorporated, Philadelphia

Purodigin, the pure crystalline digitoxin preparation of uniform potency, and *Propion Gel,* propionate compound jelly for the treatment of fungous infection of the vagina, will be featured along with other widely prescribed ethical specialties as *Amphojel, Hydase, Kaomagma with Peetin, S.M.A., Pondets, Wychol, Beplete.* Trained representatives will be on hand to supply literature and samples of outstanding therapeutic agents.

59 Zimmer Manufacturing Company, Warsaw, Ind.

At booth 59, you will find the usual fine line of Zimmer fracture equipment. Mr. Robbins will be pleased to demonstrate new items developed since the 1949 meeting.

You Save $10.00 ! !

When you attend the Annual Meeting please plan to spend a generous amount of time in the exhibits . . . both the scientific and the technical. The revenue derived from the technical exhibits saves you a $10.00 registration fee. It will assist us in our relations with the exhibitors if you will *register in at least ten booths,* for samples and literature. Also, spend time in the scientific exhibits. They have been prepared at considerable expense, and are made available for the education of those in attendance at our meeting.

Your cooperation will give us the opportunity of planning an outstanding meeting for you in 1951.

LIBRARY OF THE
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HOUSE OF DELEGATES-1950

EAST ROOM—HOTEL SCHROEDER

Sunday, Oct. 1: 3:00 p. m.: First Session
5:30 p. m.: Buffet Supper

Monday, Oct. 2: 5:30 p. m.: Buffet Supper
6:30 p. m.: Second Session

Tuesday, Oct. 3: 9:00 a. m.: Third Session

W. C. Stewart, M.D., Kenosha, Speaker

R. L. MacCornack, M.D., Whitehall, Vice-Speaker

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Section on Orthopedics	P. J. Collopy	J. E. Miller
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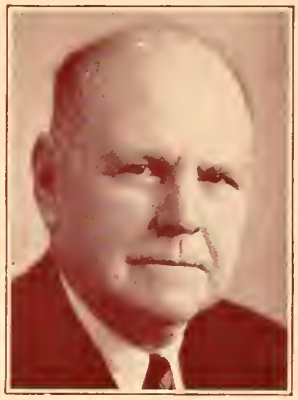

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MRS. B. I. BRINDLEY
Madison
Convention Chairman

MRS. CARL N. NEUPERT
Madison
President

Auxiliary Program

Sunday, October 1

P. M.

4:00—6:00 Registration—Fifth Floor, Hotel Schroeder

6:00 Board of Directors' Dinner—English Room, Hotel Schroeder

Mrs. Carl N. Neupert, president, presiding

Honored Guests: Past-presidents, Woman's Auxiliary to the State Medical Society of Wisconsin

Reports of state chairmen

Monday, October 2

8:30 Registration and Tickets—Fifth Floor, Hotel Schroeder

10:00 General Meeting—Club Rooms, Hotel Schroeder

Mrs. Carl N. Neupert, president, presiding

Invocation—The Reverend Everett Mac Nair, Pastor, Plymouth Congregational Church, Milwaukee

Pledge of Allegiance to Flag

Auxiliary Pledge
Leader—Mrs. Herman Wirka

Convention Announcements—Mrs. B. I. Brindley, chairman

Address of Welcome—Mrs. O. S. Orth, president, Woman's Auxiliary to the Dane County Medical Society

Response—Mrs. J. S. Huebner, president-elect, Woman's Auxiliary to the State Medical Society of Wisconsin

In Memoriam—Mrs. Herman Wirka, Madison

Convention Rules and Procedure—Mrs. Robert E. Fitzgerald, Parliamentarian

Minutes of Annual Meeting, 1949

Reports of State Officers

Reports of County Auxiliary Presidents

Report of Chairman, Committee on Credentials and Registration—Mrs. Carl Fosmark

P. M.

1:00 Luncheon—Crystal Ballroom, Hotel Schroeder

Greetings—
Dr. J. W. Truitt, president, State Medical Society of Wisconsin

Mrs. Arthur A. Herold, president, Woman's Auxiliary to the American Medical Association

Style Show—Fashions and models from the Boston Store

7:00 Buffet Supper—Empire Room, Hotel Schroeder

Entertainment by the Department of Municipal Recreation of Milwaukee

Music and Drama Section, Robert Freidel, supervisor

Tuesday, October 3

A. M.

10:00 General Meeting—Club Rooms, Hotel Schroeder

Mrs. Carl N. Neupert, president, presiding

Business Session

Election of Officers

Installation of New Officers

Induction of the President,Mrs. J. S. Huebner

Announcements

Courtesy Resolutions—Mrs. A. W. Hammond

Report of chairman of Committee on Credentials and Registration—Mrs. Carl Fosmark

11:30 Post-Convention Board Meeting—Club Rooms, Hotel Schroeder

P. M.

1:00 Luncheon—East Room, Hotel Schroeder

Address—Mrs. Paul C. Craig, Reading, Pennsylvania

3:30—Meeting of present Board members and and newly elected Board members (will immediately follow luncheon)

Mrs. J. S. Huebner, president, presiding

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Interpretation of Serum Bilirubin Values Obtained with the Ducci and Watson Modification of the Malloy and Evelyn Method

Interpretation

1. *Normal Values.*—

(*a*) In normal serum the one minute direct or prompt reacting bilirubin is low and in fairly constant concentration. It rarely exceeds 0.2 mg. per hundred cubic centimeters.

(*b*) Total bilirubin values rarely exceed 1.0 mg. per hundred cubic centimeters. Values above 1.4 mg. are definitely abnormal.

2. The *one minute direct* or prompt reacting reading measures the amount of bilirubin which has passed through the parenchymatous cells of the liver (cholebilirubin).

3. The *total bilirubin reading* measures cholebilirubin as well as bilirubin which has not passed through liver cells (hemobilirubin).

4. A normal one minute bilirubin with an elevated total bilirubin indicates a *retention* or *prehepatic type of jaundice.* There are two varieties of this type of jaundice, namely, a *hemolytic* and a *nonhemolytic form.* The later is rare; it appears in the literature under such terms as nonhemolytic prehepatic jaundice (Ducci), hereditary nonhemolytic bilirubinemia (Alwall and colleagues), familial nonhemolytic jaundice (Damashek and Singer) constitutional hepatic dysfunction (Rozendaal and Comfort), icterus intermittens juvenilis (Muelengracht) and familial cholemia (Gilbert). Where difficulty is experienced in separating hemolytic and nonhemolytic forms much help is obtained from a urobilinogen test on a stool specimen. Urobilinogen is elevated in the hemolytic and not in the other.

5. There may be an elevation of the one minute bilirubin in early infectious hepatitis before an increase in the total bilirubin is recorded. During the recovery phase it may remain elevated much longer than the total.

6. An elevated one minute bilirubin as well as a total bilirubin indicates *a regurgitation type of jaundice.* There are two main varieties of this type of jaundice, namely, a *hepatic* and *posthepatic form.*

Subdivisions under the former include *parenchymatous* and *cholangiolitic subforms;* subdivisions under the latter include *incomplete obstruction* and *complete obstruction subforms.*

In regurgitation jaundice it is thought that a rupture of blocked distended canaliculi or an increased permeability of these structures allows bile to gain access first to the lymph spaces of Disse and from there to the thoracic duct and blood stream.

Highest total readings are found in severe acute forms of hepatitis and in total obstructions of the common bile duct (25 to 50 mg.).

Summary

For emphasis, it may be said that a van den Bergh test provides us with an excellent method for the quantitative measurement of serum bilirubin, but it serves in only a limited capacity in the differential diagnosis of jaundice. It clearly separates uncomplicated cases of retention jaundice from cases of regurgitation jaundice, but help is often needed from other clinical and laboratory procedures to distinguish the subtypes listed before. The urobilinogen test on urine and stool specimens is very serviceable in this capacity, but it has its limitations also. In some instances, liver biopsy and even surgical exploration may be necessary to settle the diagnosis.

No difficulty would be encountered in the differential diagnosis if only "pure" or "nearly pure" forms of jaundice existed. Snell and Magath point out that there is never gross obstruction of the extrahepatic bile ducts without some damage to the hepatic parenchyma, and, conversely, there is never a pure hepatic jaundice without some obstruction to the small bile passages. It may also be said that hemolytic jaundice is frequently associated with varying degrees of liver damage.—W. H. JAESCHKE, M. D., *University of Wisconsin.*

REFERENCES

1. Ducci, H., and Watson, C. J.: The quantitative determination of the serum bilirubin with special reference to the prompt-reacting and the chloroform-soluble types, J. Lab. & Clin. Med. 293–300 (April) 1945.

2. Malloy, H. T., and Evelyn, K. A: The determination of bilirubin with the photoelectric colorimeter, J. Biol. Chem. 119:481, 1937.

3. Jaeschke, W. H.: Serum bilirubin and the van den Bergh test, Wisconsin M. J. 49:616 (July) 1950.

4. Jaeschke, W. H.: Quantitative determination of serum bilirubin with the Ducci and Watson modification of the Malloy and Evelyn method, Wisconsin M. J. 49:714 (Aug.) 1950.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. D., Marquette University, Milwaukee, and
D. M. ANGEVINE, M. D., University of Wisconsin, Madison

Presentation of Case*

History.—This 65 year old white male of German extraction, a cheesemaker, entered the Wisconsin General Hospital on Feb. 27, 1950, and expired on March 7. He entered with a chief complaint of shortness of breath. The onset of his present illness was April 1949, at which time he acquired a "cold," characterized by cough and difficulty in breathing. He received a course of penicillin, with complete recovery. In May the respiratory difficulty recurred, and he began expectorating one cupful of clear sputum (not blood-tinged) daily. Again he responded to penicillin.

In June the respiratory symptoms recurred but, in addition, his right foot began to swell and was tender to touch; this was followed by swelling of the left leg.

His illness then assumed a chronic and slowly progressive course characterized by a rash over the abdomen, bouts of chills and fever with temperature elevations to 102 F., dyspnea, anorexia with vomiting of greenish yellow material, and a weight loss of 30 pounds.

The patient had been jaundiced for several days two years ago. His urine throughout the preceding winter had been dark due to the medicine prescribed by his physician. His stools were also dark in color.

Physical Examination.—Physical examination disclosed an acutely and chronically ill man in obvious respiratory distress. Temperature was 99.6 F. and blood pressure 100/65. Sensorium was clouded. The skin was warm and dry with an icteric tint. There were many small petechial hemorrhages over the skin of the thorax, abdomen, and upper and lower extremities. An absence of hair was noted about the chest and axilla. There was marked cyanosis of the nailbeds of the hands, but this finding was not prominent in the lips or ear lobes. The pulse rate was 120 and of poor quality. There was grade I pitting edema over the lower extremities. The sclerae were yellow. The pupils were round and equal and reacted to light and accommodation. The vessels of the fundi disclosed grade I to II arteriosclerotic changes.

The trachea was deviated to the right. The right chest lagged behind the left. Percussion note was impaired over the right hemithorax anteriorly and the breath sounds were obscured by a harsh to-and-fro friction rub. Moist rales were present bilaterally at the bases. The cardiac apex was determined within normal limits. The heart tones were rapid and regular. They were not altered by respiration. M^1 was accentuated and snapping. A third heart sound was present near the end of the systole. A^2 exceeded P^2. No murmurs were audible.

The abdomen was slightly distended. The liver edge was palpated 6 cm. below the right costal margin and was moderately tender. The spleen was palpated 2 cm. below the left cosal margin. There was no remarkable lymphadenopathy. Rectal examination was not remarkable, and the stool was brown in color. There was no evidence of arthritis.

Laboratory Data.—Urinalysis: Specific gravity was 1.017; tests for albumin, glucose, and acetone were negative; and the microscopic examination was not remarkable. Hemoglobin was 12.25 gm., red blood cell count 4,180,000, and white blood cell count 8,738, with a differential count consisting of 78 per cent neutrophiles, 3 per cent small lymphocytes, 1 per cent large lymphocytes, 5 per cent young lymphocytes, 2 per cent monocytes, and 2 per cent unclassified cells. Reticulocyte count was 13 per cent and there were 6 to 7 per cent normoblasts. Hematocrit was 39. Volume index was 1.01, saturation index .9, and individual cell volume was 93 cubic micra. The blood platelets were definitely reduced. Blood sugar was 125 mg., nonprotein 66 mg., and creatinine 2.3 mg. per hundred cubic centimeters. Blood sodium chloride was 418 mg. per hundred cubic centimeters. Alkali reserve was 45 volumes per cent. The Wassermann reaction was negative. Sputum examination revealed Streptococcus viridans and was negative for tubercle bacilli. Blood cultures for meningococci, brucella, and other organisms were negative. Cold agglutinins were negative. Liver function studies were done. Icterus index was 40 units. Total serum proteins were 5.4 gm., with an albumin of 2.8 gm. and a globulin of 2.6 gm. Thymol turbidity was 6 units. Alkaline phosphatase was 3.6 units. Prothrombin time was 41 per cent of normal. Hanger's test was 4 plus. Blood cholesterol was 171 mg. per hundred cubic centimeters; agglutination tests for typhoid, paratyphoid, abortus, and tularemia were negative. Saline red cell fragility test was normal. Urine urobilinogen was positive in a dilution of 1:80. Fecal urobilinogen was not performed. Serum bilirubin was 12.4 mg. per hundred cubic centimeters; 6.05 mg. per hundred cubic centimeters responded to the direct reactions. The Coombs test was negative. An electrocardiogram disclosed myocardial involvement on a nonspecific basis. X-ray of the chest revealed marked pleural thickening bilaterally with evidence of pulmonary infiltration in the lower one third of the lung field, presumably on an inflammatory basis. X-rays of the skull were negative.

Sternal marrow: The sternal marrow revealed neutrophiles 7.2 per cent, eosinophiles .4 per cent, small lymphocytes 2.4 per cent, young lymphocytes 4.4 per cent, unclassified 2 per cent, metamyelocytes 5.2 per cent, neutrophilic myelocytes 8 per cent, eosinophilic myelocytes 0.2 per cent, blasts 3.6 per cent, plasma cells 2 per cent, pathologic cells 1.6 per cent, megakaryocytes 0.2 per cent, erythroblasts 5.4 per cent, normoblasts 53 per cent, and pronormoblasts 4.4 per cent.

A muscle biopsy specimen taken from the right leg revealed a thrombosed vessel undergoing organization. There was no evidence of periarteritis nodosum.

Course.—The patient's course in the hospital was characterized by progressive deterioration. His jaundice increased, and the nonprotein nitrogen mounted to 94 mg. per hundred cubic centimeters. His temperature never rose above 100.8 F. The blood cell count remained essentially stable. He was supported by parenteral fluid therapy and a course of chloromycetin and intravenous aureomycin were administered, with no beneficial effect.

* From the State of Wisconsin General Hospital and University of Wisconsin Medical School.

On the morning before the patient expired, he lapsed into a state of peripheral vascular shock which progressed into coma.

Clinical Discussion

Doctor Rotter: Two points merit attention: first, the liver function tests. It is evident that, as in many cases of jaundice, we are not dealing with a pure type. This patient had evidence of a direct reacting bilirubin which would probably signify a regurgitation type of jaundice. He also had evidence of hepatocellular disease, as evidenced by the thymol turbidity, the Hanger's test, possibly the prothrombin depression, and the increased urobilinogen in the urine. There may also be a suggestion of prehepatic jaundice, that is, the hemolytic variety; so actually all that one may infer from the liver function tests is that he probably had diffuse hepatic involvement, the nature of which cannot be determined.

Another point is the hemogram. Despite the chronicity of his illness, the patient maintained an excellent blood cell count. There was a slight normochromic anemia and a slight polymorphonuclear predominance. There was selective depression of the platelet count and indication of marrow regeneration. Why there should be extensive normoblastic hyperplasia of the bone marrow with 13 per cent reticulocytes and some normoblasts in the peripheral blood would be hard to say. This represents either previous blood loss with a good attempt of the marrow to regenerate or perhaps a hemolytic process. However, with the long standing pulmonary disease, we must consider that chronic anoxia to the bone marrow may serve as an irritant and be responsible for the immature blood cells and the normoblastic hyperplasia.

In the differential diagnosis many possibilities were considered because of the generalized systemic involvement.

Of the infectious diseases one condition that merits particular attention is brucellosis. The patient was a cheesemaker, so the occupation may have predisposed him to that infection. Brucellosis can produce a chronic febrile disease associated with splenic and hepatic enlargement; repeated pulmonary infections, however, are unusual in this condition. Blood cultures and agglutination tests for brucella were negative, and the blood cell count was not that of brucellosis. One would expect some anemia and even leukopenia, but not thrombocytopenia as this patient had. The failure of response to therapy with aureomycin and chloromycetin also militates against this impression.

Apparently those who treated him considered the condition Waterhouse–Friderichsen syndrome, since they requested blood cultures specifically for meningococci. Certainly there is hepatorenal involvement, although the azotemia may be a manifestation of prerenal disease, and the fact that there are petechiae and splenomegaly as well as fever are points that favor such an impression. However, the course of Waterhouse-Friderichsen's syndrome is not usually over 48 hours, and one would expect positive blood cultures for meningococci.

Histoplasmosis deserves some attention. It would explain the chronic pulmonary disease and also the involvement of the spleen and liver. One would expect more anemia and a leukopenia instead of a selective thrombocytopenia, as is present, but I confess that I cannot completely rule out this impression.

A few more infectious diseases probably merit mention only. Weil's disease involves the liver and kidney but is usually a much more acute illness, and there has been no exposure to rats or rat excreta. The same holds for the rickettsial diseases. Where there is a rash, a fever, and a clouding of the sensorium which may indicate cerebral involvement, the rickettsioses should be considered. Here, again, it does not explain the full picture.

Bacterial endocarditis is quite remote. The cardiac examination apparently showed no change during the illness, and in bacterial endocarditis one frequently has auscultatory changes. The negative blood cultures also are against this diagnosis.

Tuberculosis must be considered. The localization of the lung lesion is described as right lower and, although not typical, is possible. The course of the illness is not typical. The negative sputum is against but does not exclude tuberculosis.

Syphilis is a great imitator, but it would be far-fetched to assume that syphilis could reproduce this picture in a 65 year old male. The secondary variety usually causes widespread involvement, and I don't think that this is the picture of hepar lobatum or tertiary lues.

Malignancy must be considered because of age and progressive downhill course characterized by anorexia, nausea, vomiting, and weight loss. The two most probable sites are the lung and pancreas. Bronchiogenic carcinoma frequently is masked by repeated pulmonary infections that may respond to penicillin as this patient did. However, the chest x-ray is not typical of bronchiogenic carcinoma. We would then have to presume also that there was metastasis to the liver, but the finding of splenomegaly would be unexplained. Metastasis to the spleen is very rare. Carcinoma of the head of the pancreas typically produces a painless, progressive jaundice, which this patient had. Again, it would be difficult to explain the pulmonary changes. I would, therefore, exclude carcinoma.

Certain hematologic conditions merit some attention. Hodgkin's disease is a remote possibility. It can be limited to visceral structures, but one would expect some superficial lymphadenopathy, and there is none. There is no x-ray evidence for mediastinal lymph node involvement. Against Hodgkin's disease is the fact that there is thrombocytopenia. Typically the platelets are normal or increased, so I am inclined to discard this diagnosis.

Leukemia deserves only a word. The peripheral blood is not characteristic. The only possibility is

the aleukemic myelogenous variety. However, the bone marrow pattern is not that of leukemia.

The findings are somewhat suggestive of thrombotic thrombocytopenic purpura. There is thrombocytopenia, and possibly also a hemolytic anemia, but that is about all. Typically thrombotic thrombocytopenic purpura occurs in young females and is a febrile disease. The jaundice is usually not so severe. It is of a hemolytic variety, and in Singer's recent article in *Blood* he emphasizes that there are transient mental and neurologic changes, which this patient did not demonstrate. He had some clouding of the sensorium which progressed to coma and death, but certainly there was nothing that would indicate transient changes. The anemia is not so severe as one expects in thrombotic thrombocytopenic purpura, and the absence of leukocytosis is against it. In many cases of thrombotic thrombocytopenic purpura there is a leukemoid reaction, but we have no evidence for that.

Cirrhosis of the liver is a good possibility. Again we must assume that there was some independent pulmonary disease, and it may be just a complication of cirrhosis. To favor this impression we have a history that two years prior to the present illness the patient had an episode of jaundice that lasted about three days. We might suspect this represented hepatitis, and it is claimed that hepatitis predisposes to cirrhosis of the liver. We are further informed that there was an absence of body hair about the chest and axilla, and failure of a cirrhotic liver to detoxify steroids may account for such a change. Any severe liver disease would do the same, so it would not necessarily have to be Laennec's cirrhosis. Splenomegaly is explained, but one would expect other signs of portal hypertension such as ascites, evidence of collateral circulation, possibly hematemesis and epistaxis, which were absent. Fever would have to be accounted for by the pulmonary lesions. Cirrhosis with complicating bronchopneumonia, therefore, is a possibility.

On the basis of the history and findings of thromboses in a peripheral vessel and the repeated pulmonary infections, it might be presumed that thrombi broke loose and caused repeated pulmonary emboli. It is known that jaundice may occur in pulmonary embolization; however, the jaundice is never so severe, and the hepatosplenomegaly would be unexplained.

If we seek a single diagnosis to explain all the findings, a diffuse collagen disease is the best possibility. There is definite involvement of the lung, liver, spleen, peripheral blood vessels, and possibly the kidneys. We are also given the information that a muscle biopsy specimen was taken, presumably to rule in or out periarteritis nodosa, and the report was that it was negative. This does not rule out periarteritis nodosa, which may involve a single artery or be purely visceral. It must be considered as a definite possibility.

Disseminated lupus erythematosus is not quite as great a consideration, although it must be mentioned. The history is compatible with such a diffuse process. A more accurate description of the skin rash would have helped. Typically, in these diseases one would expect more evidence for renal involvement.

Of all the considerations, the best possibility is some diffuse vascular disease of the collagen variety, either periarteritis nodosa or disseminated lupus erythematosus. However, I would keep a reservation for cirrhosis of the liver with congestive splenomegaly, secondary thrombocytopenia, and complicating bronchopneumonia, and a reservation for histoplasmosis as well.

Doctor Aitken: Bedside x-rays of the chest indicate a bilateral pneumonitis and pleuritis. The cardiovascular shadow is within normal limits.

Doctor Angevine: Doctor Rotter has assumed that the case is best explained as a diffuse collagen disease. He inferred that it was related to the vascular system and mentioned periarteritis nodosa as a possibility.

Necropsy Findings

(W. G. H. 50:53)

Doctor Altshuler: After completion of the autopsy it took some time to determine the nature of the disease.

Gross Examination.—The heart revealed an obliterating pericarditis and a most remarkable valvular lesion. The tricuspid, pulmonic, and aortic leaflet of the mitral valve were covered with large fungating thrombi situated mostly at the bases of the valves and easily separable. Similar material extended into a patent foramen ovale.

The lungs together weighed 1,450 Gm. A chronic obliterating pleuritis was present. On section of the lung, thrombi were observed in the pulmonary veins associated with small infarcts. Numerous petechial hemorrhages were present over the pleural surfaces.

The liver weighed 2,050 Gm. There was evidence of a chronic fibrosing peritonitis over the dome. The hepatic vein was thrombosed.

The spleen weighed 450 Gm. Chronic fibrotic perisplenitis was evident.

Microscopic Examination.—Numerous organized (fig. 1) and recent thrombi are observed in the pulmonary vein. An extensive interstitial pneumonitis is present in all sections. The hepatic vein contains a thrombus with extensive infiltration of the wall with large numbers of polymorphonuclear cells. The liver sinusoids are dilated as are the bile canaliculi.

We believe that this case should be included in the group called idiopathic visceral thrombophlebitis migrans (Gerber and Mendolwitz, Ann. Int. Med., March 1949). A summary of the important clinical and pathologic findings of that condition follows, based upon 11 fatal cases, 6 of theirs and 5 others:

1. Affects both visceral and peripheral veins in a haphazard fashion.
2. Degree, duration, and distribution of venous affection variable.

Figure 1

3. Involves short segments of medium and small sized vessels. Sometimes, however, whole venous systems are obliterated.
4. Majority of cases are benign.
5. Disease tends to subside spontaneously in periods of several weeks to months.
6. May recur several months to years later.
7. Generally thrombi undergo canalization and, except for residua such as postural edema, no permanent change.
8. Both venous and perivenous alterations are observed.
9. The granulomatous lesions in Buerger's disease are not seen in visceral thrombophlebitis.
10. Symptoms are usually referable to lung, heart, liver, intestine, adrenal, central nervous system organs.
11. Non-localizing symptoms are: *(a)* fever; *(b)* leukocytosis—occasionally eosinophilic; *(c)* increased sedimentation rate; *(d)* anemia; and *(e)* thrombocytopenia. Of the 6 fatal cases reported by Gerber and Mendolwitz, 3 were cases of thrombocytopenia which was cyclic, possibly due to withdrawal of platelets into thrombi as in acute thrombotic thrombocytopenia. It may precede thrombophlebitis or be antedated by it. There was no depression of megakaryocytes.

Anatomic Diagnosis.—The diagnosis was idiopathic thrombophlebitis migrans involving the pulmonary, hepatic, and peripheral vessels; pulmonary infarction; chronic interstitial pneumonitis; intrahepatic obstructive cholangiolitis, vegetative endocarditis involving the pulmonary, tricuspid, mitral valves, and foramen ovale; chronic polyserositis involving the pericardium, pleura, and peritoneum; and a generalized reticuloendotheliosis.

Doctor Angevine: I have nothing to add to Doctor Altshuler's résumé of the case. We were without a diagnosis until a search of the literature revealed this disease. In retrospect, during the past few months 2 cases have come to our attention which are very similar to this one.

STATE GROUPS TO PRESENT POSTGRADUATE COURSE IN CHEST DISEASES

The Wisconsin Chapter of the American College of Chest Physicians, in collaboration with the American Academy of General Practice, Milwaukee Chapter, is presenting a course for general practitioners in diseases of the chest during April 1951. The curriculum has been officially approved by the American Academy of General Practice as an accredited course for postgraduate education. The material to be presented will be in lecture and clinic form and will cover all phases of treatment, diagnosis, and investigation in diseases of the chest.

The course will be given on four consecutive Wednesday afternoons during April in the auditorium of Milwaukee Children's Hospital. Enrollment will be limited to the first 85 applicants, and the registration fee is $25 for the entire course. Dr. Mischa J. Lustok is general chairman for the program, and Dr. Donald C. Ausman, secretary of the American Academy of General Practice in Milwaukee, is serving as secretary for the course. Reservations for the course and requests for details should be addressed to him at 2524 West Keefe Avenue, Milwaukee 6, Wisconsin.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

A. L. VAN DUSER

A native of Appleton, Doctor Van Duser graduated from the University of Wisconsin Medical School in 1938. Following practice in Stanley, he joined the staff of the State Board of Health in 1941. On leave of absence in 1946–1947 he gained the degree of M. P. H. at the University of Michigan, and on his return took over the direction of the newly formed Division of Cancer Control.

Quantitatives and Syphilis Therapy

Penicillin has removed many of the unsatisfactory aspects of syphilis therapy; but, because effectiveness of therapy is dependent on more factors than the ability to destroy spirochetes, relapses do occur. Possible relapses mean that the physician is still required to answer the often difficult question of whether or not a given course of penicillin has been adequate for each and every patient even though he has cured the majority. The remainder of this page is, therefore, being devoted to brief consideration of quantitative serologies as an aid to answering this question. First, may it be said that the adequacy of therapy must be determined by an evaluation and correlation of numerous clinical and laboratory findings. This implies and necessitates that there be a proper selection of diagnostic and laboratory procedures over a reasonable period of follow-up and that a proper interpretation of these findings be made.

The presence of syphilis organisms in body tissues produces a substance called reagin. The expression of a true positive serologic test for syphilis (S.T.S.) is dependent upon the presence of reagin. Reagin exists in quantity to give positive tests about six weeks after infection. It is highest in the secondary stage, then declines, reaching a fairly stable level in most late cases. Changes in reagin titer in a person are of prognostic value—moreso in early than in late cases—as reagin tends to parallel, although it lags behind in time, the activity or inactivity of the infection. Following adequate rapid therapy, in primary and secondary syphilis there is a fairly rapid fall in reagin, becoming negative in most cases by six months; in early latent cases, of two years or less, there will be a more gradual fall of reagin, with a negative serology at two years in more than half; in late cases the reagin falls slowly over long periods of time, becoming negative in less than half the cases. In all stages of the disease a continual decrease in reagin is usually compatible with adequate therapy; conversely, a sustained rise, for at least three monthly quantitatives, usually is not. An occasional single tube fluctuation has no significance, as it represents laboratory variations.

Chart 1 is presented to show the relationship of serologic tests to the quantity of reacting substance, reagin. One unit of reagin, the small amount necessary to cause a complete—so-called 4 plus—positive complement fixation or flocculation qualitative reaction, spans about 1 per cent of the average range of reagin in syphilitic persons. Less than 1 unit produces incomplete reaction from less positive to doubtful to frankly negative. If the test is positive, it is obvious that differences between reported 1 plus, 2 plus, 3 plus, and 4 plus from 1 unit are almost of no significance quantitatively and cannot be interpreted to mean important quantitative changes. Qualitatives are diagnostic, not prognostic, tests. Their use as prognostic tests is usually wasting a laboratory's time because they cannot tell us what is happening to the reagin titer in the 99 per cent portion of the average reagin range. Repeated ones will all be "4 plus," unless the reagin has fallen to the small incomplete or negative 1 per cent zone. Reagin in many cured syphilitic persons never reaches such low titers. Quantitatives measure in units the amount of reagin present in a serum. Repeated, monthly or thereabouts, *quantitatives* will record changes in reagin titers following therapy. In nearly all syphilitic persons these changes can be correlated with clinical and other laboratory findings such as cerebrospinal fluid to provide reliable information on the adequacy of treatment given.—ARTHUR L. VAN DUSER, M. D., *Director, Division of Venereal Disease Control.*

Units of Reagin	0	1	2	4	8	16	32	64	128	256	Lab report.
Quantitative Range	0 incomplete	+	+	+	+	+	+	+	0	0	Positive, 64 units or in 1:64 dilution
Qualitative Range	0 incomplete ± + ++ +++ 4 +						Also ++++				Positive 4 plus

CHART 1.—*The relationship of serologies to the quantitative range of syphilis reagin; a theoretic, positive serum of 64 units is used.*

Progress Report on American Medicine*

By ERNEST E. IRONS, M. D.
Chicago

PHYSICIANS of this nation are deeply concerned with the prevention of sickness and injury of all our fellow citizens. The care of the sick, the prevention of disease and the alleviation of suffering are the center, the impelling motive, the inspiration, around which are built all the activities of the medical profession. The universally recognized accomplishments of medicine by the combined efforts of research and the application of new knowledge in careful and intelligent practice have been attained in a nation of free enterprise and, in the past, sound economy. The problems of medicine are closely integrated with the economic and social conditions of our people. They are mutually interdependent.

The application of science and discovery make possible continuous advances and new achievements in prevention and control of disease—better medicine. There are, however, inherent limitations in medicine; physicians cannot create bodily immortality. Death cannot be prevented; it can only be postponed. All that the physician can do about death is to change age and cause. Proponents of nationalized medicine seem to assume that there is some absolute standard of medical practice and talk glibly of "adequate" medical care as if they could set a standard and a limit to medical progress. Medicine is not static. With other men here, I have seen changes in medicine in the past 50 years, during which time what was regarded as good medical practice has become entirely inadequate today. By the very nature of medical progress, it can never attain perfection, because the goal moves ever in advance. One thing is certain, however, you cannot improve medical care simply by setting up a uniform assembly line system—which always has and always will make it worse. Already in England there is now being advertised private insurance to protect against the dangers and delays of government care. This indicates that even in Socialist England the people are finding that they must turn again to private enterprise, to protect themselves against the evils of socialism.

This development in England is so significant that I wish to read a few sentences from an advertisement of the British United Provident Association which appeared in the *London Punch*, May 10, 1950.

"Which would you choose in the event of illness? Private treatment or the General Ward!

"The National Health Service ensures that everyone receives medical and, if necessary, hospital treatment in the event of illness or operation.

"To many people, however, the necessary formalities, the waiting and, finally, treatment in a general ward, are disconcerting both in anticipation and in practice.

"In view of the fact that serious illness or the need for operation so often strikes without warning, it is no more than obvious wisdom to safeguard yourself and your family without delay. . . ."

We as physicians are resolved that the continuation of the marvelous progress in America shall not be thwarted or diverted by the introduction of a foreign ideology which, as in past decades, now elsewhere before our eyes, is destroying the quality of medical care and delaying the correction of obvious faults. We are well aware of the social and humanitarian necessity of provision for the health care of the indigent and the victims of ill fortune whose plight is due to both economic and medical factors. In former days this was accomplished by local communities and more recently by many excellent city and state aid programs, to which physicians already have given personal and professional support. This aid can be supervised best under local administration, and it then can reach the needy without being diluted by the impositions encouraged by socialistic promoters of the welfare state. We already have achieved in this country the best medical care in the world.

Last month we were favored by the pronouncement of a spokesman for the political backers of government medicine to the effect that now they would be pleased to give up the program for compulsory sickness insurance if medicine could offer any other solution for improving the medical care of the nation. This is an official confession of the bankruptcy of the program plaintively described as "so close to the heart" of their political leader. Recent political events have no doubt played some part in recasting Act II of this modern political Comedy of Errors. An intelligent expansion of sound and helpful programs will succeed without unnecessary national legislation. We shall do best by encouraging more individual responsibility, more self help and fewer treacherous governmental crutches, more honest statements of fact and less deliberate deception and playing with the truth, more willingness to work and less national political tinkering.

Our Medical and Economic Problem

The objectives of medicine and their relation to our entire American economy are now much better understood by the people of this country than at

* Address of President Ernest E. Irons before the House of Delegates, American Medical Association, San Francisco, June 26, 1950.

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the outset of our educational campaign. Let us review the progress of this critical fight of medicine and of all patriotic groups to defend our America from the external and internal attacks of socialism and its twin, communism. Prior to two years ago the insidious growth of socialistic practices promoted in the name of social and economic welfare had placed businesses, medicine and even legitimate government on the defensive. In this gigantic malignancy a few ambitious but unscrupulous men did not hesitate to falsify statistics and sow seeds of discontent and distrust, audaciously using the familiar Marxian technic of the "misery of the masses" in a country the people of which are better fed, more prosperous and more productive than in any nation in history.

The subjugation of medicine to political purposes has always been an early objective in the promotion of the socialist welfare state. Nibbling at the personal responsibility, initiative and freedom of the individual by supposedly innocent and superficially attractive welfare measures went on for years without much opposition. Physicians and others interested in the welfare of the public failed to recognize this process of undermining the originally strong pioneer spirit of our citizens. As professional men and as citizens we failed to realize the gravity of this attack on the moral foundations of our country. After the preliminary softening of the national fiber by alleged temporary welfare promises and benefits, the direct attack on medicine was intensified and medicine found itself in the front line in defense not of medicine alone but of the American way of life.

The Offensive

Now, after two years, the real threat of socialism is better understood by our citizens, and physicians together with other patriotic groups are on the offensive. Much of the previous national inertia which affected business and labor groups as well as medicine has been overcome. Thousands of nonmedical citizens and leaders, at first impressed by the false premises of arguments for compulsory sickness insurance now realize its inevitable destructive effects on quality of medical care, on the independence of the American citizen and on the economic stability of the nation. Still others, though now informed, unfortunately hesitate to "lose face" by admitting that they were deceived. Members of the medical and allied professions are better united in understanding and in purpose than ever before and are determined that there shall be no shackling of medicine and no compromise with the evils of socialism.

A vigorous campaign for voluntary insurance by medically sponsored groups and by commercial insurance companies has brought hospital insurance to more than 68 million, and protection against surgical costs to 40 million and for medical costs to 16 to 18 million persons. Sixteen thousand persons are being added daily to those participating in voluntary health insurance plans. Meantime the professional accomplishments of the medical profession in the prevention and cure of disease have proceeded apace with continuing reduction of illness and lowering of death rates. This progress will be still more rapid when we have disposed of this socialist threat to America.

The general public has been made increasingly aware of the dangers of socialized medicine and socialism, and resolutions in opposition to compulsory health insurance and in favor of voluntary health insurance have been adopted by more than 10,000 organizations. More than 6,600 are nonmedical and include farm bureaus, the American Legion, civic and women's clubs, religious groups, insurance groups and other professional organizations. This is indisputable evidence of the disgust of thinking persons across this land, independently of the political parties, for the insidious socialistic programs which will cost the average man more in taxes than he can ever receive in benefits.

Confusion

A few months ago it became evident that a bill for the nationalization of medicine could not pass this Congress, and so the program of its proponents was changed and an attempt was made to introduce further fragments of socialism by means of small federal contributions to this or that new welfare agency. A number of such bills were introduced carrying almost no financial commitment, obviously intended to set up a pattern—a foot in the door—so that later these little bureaucracies could grow. In other bills it has been proposed to give federal aid to projects which affect many phases of our economic, educational and medical life. Sometimes these proposals are urged on the basis of alleged need and at other times recommended as progressive social projects, often with the disclaimer of any present intent of local interference by government bureaucracy. No mention is made of the Supreme Court decision of 1942, which asserted the right of government "to regulate that which it subsidizes."

The American people would not now accept socialism as a substitute for our American democracy. However, there still is much confusion in the minds of the public and of many physicians as to the importance of the so-called fringe bills. For the past 15 years the American people have been conditioned to the gradual growth of welfare projects not only in medicine but in other fields of attempted economic planning, which historically in other nations have always ended in economic dictatorship. Economic planning and welfare projects have been promoted as devious alternative measures in preference to meeting economic and social difficulties on the basis of individual responsibility and incentive of each citizen.

Responsibility for the social welfare of our people, in which all physicians as well as public-spirited citizens are deeply interested, has been gradually shifted from the local community and the state to

a federal bureaucracy on the fallacious ground that only federal government could take care of exaggerated claims of alleged tremendous gaps in social and medical care. Great advances in medical and social care already made at state and local levels are interfered with by severe taxation of a wasteful federal government which always exacts an excessive brokerage for the support of the ever growing bureaucracy parasitic on each project. Thus the public and the medical profession have been conditioned to progressive steps which tend to remove from group after group of our citizens the necessity of personal effort. This process of softening and regimentation, whether by direct subsidy or by federal loans to small businesses, has been tolerated by this nation more readily following its temporary regimentation by total war.

A welfare measure, superficially attractive and perhaps relatively innocent in itself, forms a precedent; it is then easy to add a further welfare measure on the supposition that it is similar and perhaps complementary to previous legislation. Thus it is not surprising that many physicians and other thoughtful groups find it difficult to determine where such legislation should stop. This difficulty is also encountered by members of Congress who in the past have taken positions of compromise, which no doubt were strategically expedient at the time but which have persisted to plague those who now see the entire economic and social picture more clearly. A number of laws with a socialistic trend were formerly favored by members of the Congress before they had opportunity to think things through.

The only sound and consistent position for American medicine and the American people is that of opposition to any measures related to the progress of the socialist welfare state. Worthy objectives have been habitually used to camouflage national proposals essentially dangerous to our medical, social and economic well-being. These objectives can be attained more safely and effectively by local and state efforts after appropriate thorough education of the public.

The offensive battle of the medical profession, in addition to outspoken opposition to the socialization of medicine and the socialization of America, must include opposition to fringe bills. We must clear our thinking from the muddle in which it has been placed by the insidious growth of welfare measures of the past 15 years, many of which were surreptitiously planned as steps toward socialism. Help for the needy and distressed can be supplied without destroying their individual freedom and subjecting them together with their fellow citizens to slavery of the police welfare state.

The successful program of local and state service to the sick and needy must not be nullified by dominating interference of selfish federal bureaucracies. Programs for preventive medicine must be advanced and not diverted by the destructive effects of socialized medicine on the quality of medical service to the public.

National Solvency

Medicine will flourish and progress only in a sound economy. Our efforts, therefore, must concern not only the interests of good medicine but also the maintenance of free enterprise and solvent finance in American life. We must labor to maintain the personal freedom and initiative of our citizens. Our funds then will be available to help the needy and improve the conditions of other citizens by local measures; citizens will not lose their initiative and sense of personal responsibility to the state. In this national emergency, whether physicians or business men or farmers or laboring men, we must not be guilty of cowardice or unwillingness to stand up and be counted. We shall have to oppose even some of our medical friends who have been deceived by the rosy red picture of the welfare state.

This is not a partisan political fight; it is a crusade in which every right thinking doctor who values freedom of opportunity, free enterprise and the maintenance of high standards of medical practice must join.

You, the members of this House of Delegates, represent all the states in the Union. It is by your efforts and influence that every doctor can be shown the part which he must play in the present crisis. We as physicians have traditionally shunned political activities. During war physicians have always joined in efforts to save our republic. Now is the time again to come to the rescue of our country, this time to help save it from socialism.

Physicians in every community must accept and take on the responsibilities of citizenship. First they must register and then vote. A survey taken recently disclosed that 13 per cent of physicians in the localities surveyed were not registered; in fact, 22 per cent did not vote. In this respect they are not different from other well meaning and patriotic groups; for example, 26 per cent of bank employees and executives were not registered and 32 per cent did not vote. The same survey revealed similar figures for pharmacists and ministers and for members of chambers of commerce.

We, as physicians, must pause in our practice long enough to inform ourselves of the issues which confront our country. We must realize that the country is being undermined by treacherous proposals initiated in the name of doing good. We must take an active part as citizens in our government. The problem is simply stated: Compulsory health insurance is socialized medicine despite recent frenzied political efforts to escape the issue. To socialize medicine is to socialize America. The effectiveness of our city, county and state aid programs for the needy and indigent, the further development of preventive medicine, the rapidly growing professional and commercial voluntary insurance against the financial hazards of illness, the multitude of fraternal and religious charitable and self-help agencies, must

not be jeopardized and ruined by the imposition of deceptive and wasteful socialistic proposals advanced by those who hope to profit politically at the expense of the freedom of the American citizen.

Do we as a people wish to rush down the socialist road after Great Britain? The answer obviously is "no," but we must present forcefully our convictions. We as physicians and citizens shall not relax until, with other patriotic groups in business, on the farm, in the other professions and labor, we shall have rolled back the socialist flood that threatens to engulf our American freedom and our solvency.

As I conclude my year of service as President, may I thank you again for the honor you have done me, for your own efforts in our crusade and, most of all, for your support, which has made a trying and difficult year much easier. Among the compensations have been the cooperation of the general medical profession and the unity of physicians and of other patriotic groups in our fight to maintain freedom of medicine and freedom of America.

AMERICAN MEDICAL ASSOCIATION ANNOUNCES DATES OF CLINICAL SESSION

The fourth clinical session of the American Medical Association, designed primarily for the general practitioner, will be held in Cleveland, December 5–8. The scientific sessions and exhibits will be presented in the Cleveland Municipal Auditorium. The meeting of the House of Delegates will be held in the Statler Hotel.

Further details on the program will be published in the October issue of *The Wisconsin Medical Journal.*

Introducing the Guest Editorialist

Norma Lee Browning is a special assignment reporter and feature writer for *The Chicago Tribune.* In 1944 and 1945 she visited Veterans' Administration hospitals in all parts of the country and wrote a series of stories about their administration and work and human interest highlights about the patients.

In 1949 and 1950 she did two series of stories based on personal investigation of quack medical practices. In the course of the two investigations, each covering six or eight weeks, she presented herself as a patient to approximately 50 assorted healers. The nonexistent ailments diagnosed (she had received thorough physical examinations and a clean bill of health by competent physicians selected by The Tribune's Dr. Theodore R. Van Dellen) and the treatments prescribed formed the basis of the series of stories.

A gratifying by-product of the series was increased activity by state enforcement agencies that resulted in license revocations and prosecution for practicing without a license in several cases.

Miss Browning holds two degrees from the University of Missouri (A.B. and B.J.) and an M.A. degree from Radcliff college. She is married to Russell J. Ogg, a free lance photographer. She has been employed by *The Chicago Tribune* for six years. She has covered everything from fashions to murder but has received her greatest recognition for feature series.

Before coming to *The Chicago Tribune,* Miss Browning worked for the *Los Angeles Examiner.* She has done considerable writing for national magazines, several articles on assignment for *Reader's Digest,* for example.

Loyalty Unlimited—Is it a Virtue?

I SHOULD like to make a couple of points clear at the start: My experience does not include contacts with the State Medical Society of Wisconsin, with any Wisconsin county medical societies, or any members of those organizations. My observations, therefore, should not be interpreted as applying especially—or necessarily at all—to activities of organized medicine in Wisconsin. The shoe should be worn only if it fits.

Since this forum has been offered, however, I cannot pass up the opportunity to present a conclusion that I reached while investigating quack doctors and writing about them.

At no time did *The Chicago Tribune* or I set out to judge what is quackery in medicine and what is ethical practice. The investigation on which my news articles were based started from leads provided by the American Medical Association's Bureau of Investigation, the Federal Food and Drug Administration, the Chicago Better Business Bureau, and the Illinois state licensing agency. The most pertinent and valuable information came from the A.M.A. bureau.

It was this bureau that briefed me on the infamous Drown machines. Their users assert that these machines diagnose and cure any ailment known to science—and do it by remote control by means of radio waves! Operators of Drown machines readily diagnosed and offered to cure me of a multitude of diseases which, of course, I did not have.

One Drown operator was a charming, elderly gentleman. He took my $50 for a diagnosis and offered to cure me with treatments lasting several months and costing $100 a month. He was a member in good standing of the local and state medical societies and a fellow of the American Medical Association.

When his Drown activities were called to the attention of the local medical society, a grievance committee was summoned. Everyone on the committee agreed that the situation was embarrassing and that something should be done about it. The committee decided to meet again—later. Subsequent meetings were held and the situation was deplored roundly, but nothing was done about it.

As a representative of The Tribune, I explained that when the article was published readers would wonder why the medical society permitted one of its members to practice such flagrant quackery. One member of the grievance committee suggested that could be avoided by omitting from the article the reference to the quack's affiliation with the society. I explained that I considered his medical society membership to be pertinent background and tried to describe my conception of integrity in news reporting.

The grievance committee ultimately cited the doctor to show cause why his medical society membership should not be terminated. When the newspaper article exposing the man as a quack was printed, it included the fact that charges had been filed against him and that a hearing was scheduled to consider his expulsion from the society. When he was expelled, several weeks later, The Tribune printed that fact, too.

Again, in the course of investigating the Koch treatment, which probably is the best known brand of quackery currently being used to prey upon the sick, I found one doctor in Chicago and two in Detroit who offered to cure my arthritis, diabetes, cancer, or anything else I listed in self-diagnosis, with one shot of glyoxylide and a lot of hocus-pocus, including bottled—not canned—apple juice. These three quacks were members of local and state medical societies. One was dropped in April by his county medical society after his activities had been called to the attention of the group. At this writing, the other two quacks still are members. (In fairness to the Wayne County [Mich.] Medical Society, it should be explained that the Michigan quack who retains his good standing is a member of a rural county medical society.)

The point I want to make is this: Organized medicine works hard and effectively at the never-ending task of curbing the quackery of osteopaths, naturopaths, naprapaths, chiropractors, unaffiliated M.D.'s and assorted other so-called healers.

When a member of the lodge is caught engaging in the same nasty business, however, organization loyalty in many cases seeks to shield him from exposure. Other members of the society—the ethical doctors—are reluctant to testify against him at license hearings or in court proceedings. The societies to which he belongs are hesitant to expel him. A quack's membership in a reputable medical society hampers even outsiders who try to put him out of business.

It seems to me that ethical doctors must accept the responsibility of policing their own organizations. I am not suggesting that every complaint by a disgruntled patient should be grounds for expelling a doctor from a medical society. But the operation of the Drown machines or the use of the Koch treatment is something entirely different. It seems to me that such a practitioner is a quack and that he has sacrificed his right to the loyalty and the support of the ethical members of his profession.

Norma Lee Browning

THE MEDICAL FORUM

DOCTORS UP TO AGE 50 ARE ELIGIBLE FOR DRAFT

Medical Reserve Officers to Be Called Under New Priority Plan

Washington, D. C., Sept. 9.—Army, Navy and Air Force medical reserve officers will be called to active duty on the basis of a new system of priorities just developed by the Secretary of Defense.

Excluded from the new priority plan are:

1. Members of "organized" reserve units—that is, those assigned to TO/E, T/D and other organized units which are authorized paid drill and training periods and point credit toward retirement benefits;
2. Those pursuing a 12-month medical internship, whose recall will be delayed until completion of this training.

The first group to be called includes medical reserve officers who received all or part of their professional education in the Army's ASTP program or the Navy's V–12 program, and who have had no military service as medical officers. Substantially all of this group will be ordered to active duty before calls are made for other classifications.

In the second priority group are those who participated in the ASTP or V–12 programs and who have had subsequent military service, with those having the least service to be called first.

The third priority includes all other reserves officers.

The Army, Navy and Air Force will furnish information in advance to Dr. Richard L. Meiling, Director of Medical Services, Department of Defense, whenever the departments plan to call reserve medical officers to active duty, with these plans subject to review by the Director of Medical Services and the Secretary of Defense prior to issuance of orders to the reservists.

Exceptions to the priority system may be authorized by the Director of Medical Services when individuals with special qualifications are required to meet military needs, since older physicians highly skilled in certain specialties must be provided from time to time.

In carrying out this policy, the three military departments have been instructed to review their previous procedures in issuing orders for call to active duty, in order that those individuals who have received orders but have not yet reported for duty may be reconsidered on the basis of this priority system.

Important Notice!

The Secretary of Defense has ordered the three military departments (Army, Navy, Air Force) to review their previous procedures in issuing orders for call of medical reserve officers to active duty, in order that these individuals who have received orders but have not yet reported for duty may be reconsidered on the basis of this priority system.

AEC Says It Has No Treatment for Radiation

Washington, D. C., Sept. 1.—Answering a press conference question, an Atomic Energy Commission spokesman summarized medical treatment for atomic bomb injuries of three sentences:

"The principles of therapy developed during the last war will apply for blast and burn injuries. The principles of treating shock and blast are just the same. For ionizing radiation we have no specific therapeutic treatment right now."

This terse reply gets considerable treatment in scientific detail in an AEC publication just released, "The Effects of Atomic Weapons." This 456-page book, thick with diagrams and illustrations, may be purchased from Government Printing Office, Washington, D. C., for $1.25.

Expect First Call Within 60 Days of Registration; Priority System Set Up

Washington, D. C., Sept. 10.—The socalled "doctor-draft" bill providing for the induction of medical, dental and allied specialists was signed by the President on September 9.

Under the new law, physicians and dentists who have not reached the age of 50 and are not members of military reserves must register. Veterinarians, optometrists pharmacists, osteopaths and other specialist categories specified by the President must also register.

Four Priorities

Any registrant is subject to induction if acceptable to the military. The law provides that registrants will be called up on the following priority:

1. **Former ASTP and V–12 men who have not served on active duty (military, Coast Guard or Public Health Service) and other deferred from service to continue their education during World War II, and who have had less than 90 days of active duty.**
2. **Members of the above groups who have had more than 90 days active duty but less than 21 months.**
3. **Other men (not ASTP or V–12 trained) who did not have active service subsequent to September 16, 1940; this could include postwar medical graduates as well as other physicians who have not served and have not reached their 50th birthday.**
4. **All others, including World War II non-reserve veterans. Men in this group will be called on the basis of extent of duty; those with the least duty first.**

The draft is not expected to take actual effect until about 60 days after the registration. Registration

(Continued on page 840)

State Civil Defense Director Named; Says Model Plan to Be Ready Soon

Madison, Sept. 18.—Washington's long-delayed model civil defense plan is ready and will be released to state and local civil defense heads shortly, reports Col. Ralph J. Olson, Madison.

Col. Olson, Madison businessman, was recently named as state civil defense director.

He and defense directors from other states, as well as their staffs, were briefed on the plan in Chicago when they witnessed a trial run on Chicago's civil defense setup.

Dr. Carl N. Neupert, state health officer, has ben given the job of heading up the medical aspects of civil defense. He expects to announce plans for handling medical and public health problems in disaster within a short time.

"As I see it, civil defense is largely a local responsibility, with whatever guidance and assistance the state can give the municipalities," Col. Olson declared.

He said he would "use existing facilities and agencies as much as possible" in setting up a state defense network. Although Dr. Neupert was the first of Col. Olson's deputies to be appointed, he will later name the heads of such phases as transportation, evacuation, and communication.

The work of finding and training thousands of volunteer workers in state communities will be a "tremendous task," in Col. Olson's opinion, and one that local government units will have to spend some time on.

Col. Ralph J. Olson

Fight Compulsory Cash Sickness Disability

Madison, Sept. 1.—The Wisconsin State Chamber of Commerce is undertaking a widespread campaign to secure public recognition of the fact that voluntary cash disability plans to protect workers from wage loss through illness or injury arising off the job are so available and adequate that compulsory legislation is neither necesary or desirable.

The program involves preparation and distribution of leaflets, news releases to newspaper, radio stations, magazines and house organs, operation of a speakers bureau, local and area meetings and contact with all groups concerned.

WVMSA Pays Doctors Nearly $1,000,000

Madison, Sept. 13.—Nearly $1,000,000 has been paid to Wisconsin physicians by the Veterans Administration through the Wisconsin Veterans Medical Service Agency of the State Medical Society as payment for their services to veterans with service-connected disabilities.

This is the report of Dr. J. S. Supernaw, Madison, chairman of the operating committee of the agency. Actually, a total of $946,985 was paid to the doctors in the period from Nov. 1, 1946 to August 15, 1950.

BIEMILLER BILLS GET THE BOUNCE

Washington, D. C., Sept. 5.—No sooner had long-standing proposals for federal aid to medical education been shelved by Congress than Rep. Andrew J. Biemiller (D., Wis.) introduced another scheme for aiding medical, dental and allied professional schools.

With the same decisiveness as in the previous bill, the House Interstate and Foreign Commerce Committee proceeded to put his latest proposal on the shelf. The vote was 15–8.

Biemiller went immediately from the committee room to the House floor where he delivered an incisive 60-minute speech castigating the AMA and "political medicine men" for their part in defeating this and other national health legislation during the current session.

Doctor Draft

(Continued from page 839)

is expected to occur within a few weeks at "appropriate points" in the community.

After registration, Selective Service will place the man in one of four classes listed above. Then, if to be called, he will be ordered up for his physical. Following this, he will have 21 days to set his affairs in order before reporting to the Armed Forces induction station. Subsequently he will be offered a commission and assignment to a service.

All Reserves Get Bonus

A physician who has registered may still seek a reserve commission if he is acceptable to the military reserves. If the man applies for and is granted a reserve commission, he will come under military orders and Selective Service will not process him further.

Every reserve officer called to duty on a voluntary or involuntary basis will receive an extra $100 per month. Men required to register under the draft law also may qualify for the $100—but only if they volunteer prior to their actual induction.

Deferments Authorized

Actual deferment is at the discretion of local Selective Service boards, and the draft law states that the President is authorized to provide for certain deferments among medical men. Action under this clause would be based on the registrant's previous military service, his dependency status and any undue hardship that might ensue.

The medical profession will advise the Selective Service on the national level (though a National Advisory Committee) on men to be called, but whether local advisory committees will be established and made effective is not definitely known as yet.

Civilian Needs Considered

The law also states that national, state and local committees shall give appropriate consideration to "civilian as well as military medical requirements." This opens the way to deferments for men in critical "doctor-shortage" areas.

Military medical officers hope that the draft law will bring in enough volunteers to meet current requirements, although they are prepared to use the law's authority for mandatory inductions.

Other Draft Law Data

Transfer of medical officers from one service to another is authorized, with consent of the officer and of services involved.

Officers are protected in promotion, retirement and pay.

Any physician who served in the armed forces or PHS after September 16, 1940, and is recalled, may be "promoted to a grade commensurate with his education, experience and ability."

"It is the sense of Congress" that Selective Service deferments will be granted to premedical, predental and allied students in numbers equal to the present such enrollment.

It is anticipated that advisory committees established under the law will operate like Procurement and Assignment in World War II.

Reserve Officers Urged to Check "Spec" Numbers

Madison, Sept. 11.—Medical officers in the reserve corps of the Army, Air Force and Navy are urged to notify the Organized Reserve Corps or the Commanding Officer of their respective units if they desire to effect a change in their specialty (MOS) numbers.

At a meeting in Chicago on Sept. 10, Dr. F. L. Weston, Madison, chairman of the Committee on Military Service, informed military officials in attendance that many reserve physicians have, by virtue of their training and practice since World War II, qualified themselves for a change in their specialty number.

Because the Army is calling reserve officers on the basis of its need for physicians of certain specialty and rank, it is important that reserve officers make sure the Army has current information on this matter.

Col. James Q. Simmons, MC, chief of the Officer Procurement Branch of the Army, said that the organized reserve corps has sent questionnaires from time to time to all reserve officers asking for information about specialty numbers, but "seldom are they answered." He added that it was the "responsibility of the individual reservist to keep his specialty number up to date."

ASTP and V-12 Men Won't Be Enough

Washington, D. C., Sept. 5.—In House debate on the doctor-draft bill, Chairman Carl Vinson of the Armed Services Committee said that ASTP and V–12 trained physicians who have not served could supply all military medical requirements for the next year.

However, the 3,000 ASTP trained men and the 2,613 V–12 physicians are available on paper only. Military planners warn that physical handicaps, practice in doctor-shortage areas and other factors will reduce this potential supply well below the requirements.

Women Doctors Win Equal Rights in Army

Washington, D. C., Sept. 11.—Some parts of Capitol Hill have been ablaze in the past few weeks over "equal rights" for women in the Armed Forces.

And from all appearances, the women are winning.

The Department of the Army has announced that effective immediately women doctors may be commissioned and assigned as reserve corps officers. Moreover, they will have equal opportunity with male physicians as regards rank, pay and retirement benefits. The Air Force expects to follow the Army's action within a short time.

But with the Navy, it's a different thing. Navy women physicians will continue to serve under the same rules that apply to Waves. Thus, a Navy woman doctor becomes a Wave and can only rise to the basic rank of lieutenant commander subject to Wave retirement regulations. In the Army and Air Force, a woman physician becomes a part of the medical corps and could conceivably rise to rank of general.

Army to Continue Cooperation With SMS

Madison, Sept. 11.—Officials of Fifth Army in Chicago have indicated to members of the Committee on Military Medical Service of the State Medical Society that they will continue to work through this committee in the selection and call-up of any army reserve medical officers.

"Doctors Won't Be Wasted," Surgeons General Promise

Washington, D. C., Sept. 5.—Sharp criticism of the way physicians had been used by the Armed Forces in World War II has brought a quick reply from Carl Vinson, chairman of the House Armed Services Committee.

He says that he has "assurances" from the three Surgeons General that physicians would not be wasted this time. In addition, the American Medical Association's Council on National Emergency Medical Services, under Dr. James C. Sargent, Milwaukee, has made considerable progress in achieving professional advisory status to the National Security Resources Board and to the Surgeons General. This relationship is most certain to result in better use of skills.

IT TAKES MORE THAN WORDS

Time's policies are written in the layman's language. We want our policyholders to understand every printed word. But it takes more than printed words! It is the intent of the company behind the policy that really counts.

Time claims are not ADJUSTED. Our claims are REVIEWED as a means of giving all possible assistance when a policyholder becomes a claimant.

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Council Defines "Income" for Family Policy Holders

Madison, Sept. 1.—A new definition of income in relation to the number of persons covered in a family policy of both Blue Shield and the Wisconsin Plan was accepted by the Council at its August 19–20 meeting.

The Coordinating Committee of Prepaid Health Plans brought the matter to the attention of the Council after several problems had arisen out of the situation where more than one policy is carried separately by members of the family, both of whom are wage earners, or where a member of a family carries a policy not covering the entire family.

The Council declared that, in the decision as to eligibility for full payment, the entire income of eligible members of the family be considered and that the income should not be divided as between those with individual coverage.

One instance was the case of a husband who carried a single policy in his employment, while the wife, also employed, was covered by an individual policy.

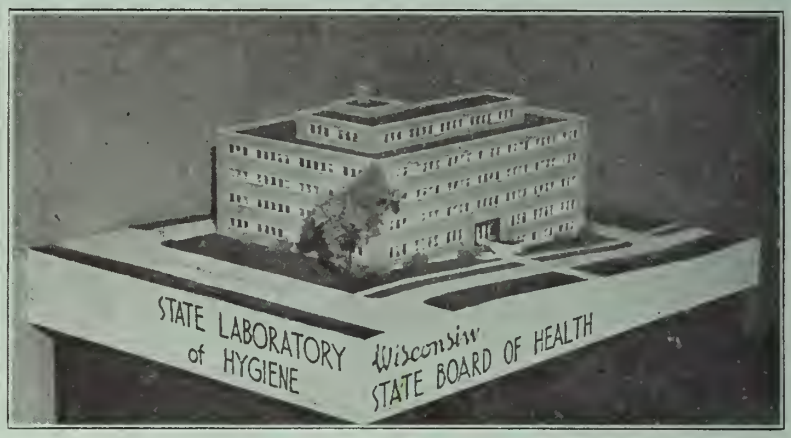
The Society's health programs call for full payment where a person without dependents is earning $2,000 a year or less, and in the case of those with dependents, where the income of the insured persons, and that of his eligible dependents, is less than $3,600 annually.

By the device of purchasing two policies based on individual incomes only, either of the two would be entitled to full payment although their combined earnings may exceed the income limits.

Polk County Starts Diabetes Control Drive

Balsam Lake, Sept. 1.—A diabetes control program was launched by the Polk County Public Health Council at the end of August when Dr. L. J. Weller, Osceola, president of the Polk County Medical Society addressed the Council at a public meeting.

He urged all the county's residents to have the simple diabetes test made by their family physicians. He described the disease, its symptoms and control. The program was part of the health council's education program for the county.



SCALE MODEL OF THE NEW STATE LABORATORY OF HYGIENE. Architects are now working with Dr. W. D. Stovall, laboratory director, and officials of the State Board of Health to complete drawings and floor plans. Bids will be let soon, and construction is expected to start before the end of the year. The new laboratory will be located between the Wisconsin Orthopedic Hospital and Agricultural Hall on the University of Wisconsin campus.

Press Association Fights Quack Advertising in Weekly Papers

Madison, August 25.—The quacks and cultists would go out of business—and the public would be a whole lot safer—if every newspaper followed the advice of the Wisconsin Press Association.

"Think of the temptation that is placed before invalids, cripples, and other unfortunates when their newspaper contains 'phony' want ads offering cures for about everything under the sun. There is no excuse for any publisher running a two-bit want ad that offers any kind of cure or remedy."

That advice, given in a recent bulletin to all its members, is just another step in the long campaign that the Wisconsin Press Association has waged in the interests of public health. The Association, under business manager Carl Zielke, Madison, has been primarily responsible for the elimination in weekly newspapers of misleading and unreliable advertisements that play upon the credulous sick.

Recently, Mr. Zielke wrote to members of the Wisconsin Press Association:

"We are all hepped up because there are people who believe they can send any kind of an advertisement to a weekly newspaper and get it in print. Our mood has not improved by this weeks offering from one advertising firm. They sent a three-quarter page patent medicine ad for a product nationally famous by virtue of its radio and newspaper plugs. The headline says: 'Don't be satisfied with only temporary relief. Now it is possible to treat the cause of any sickness', (and in smaller type) 'due to deficiencies of Vitamins B_1 and B_2—niacin and iron.'

"Then too, when you get to the bottom of the ad you find that the charming fifteen people who are illustrated by the products makers are not those from whom the testimonials have been secured—the smallest type in the ad carries this message: 'Photo by Professional Models.'

"There may be room for ready-print sections in the weekly newspaper field, but some good publisher should protest vigorously to keep the advertising clean and reliable.

"We suspect that the advertisement mentioned above is in keeping with all laws, rules and regulations governing advertising. We do not say it is fraudulent. But, we do think that the advertisement with 'Photos by Professional Models' and the headline 'To Treat Any Sickness' is misleading."

The Wisconsin Press Association continually informs its members of similar advertisements being placed by quacks and cultists from all over the country.

Blue Shield (WPS) Covers 190,000 Persons; New Surgical–Maternity Contract Offered

Madison, Sept. 13.—Blue Shield of Wisconsin (Wisconsin Physicians Service) an agency of the State Medical Society, reports that steady growth throughout 1949–50 has brought the plan's coverage to 190,260, an increase of 48,701 in the last year.

Dr. E. M. Dessloch, Prairie du Chien, chairman of the directing board of the Blue Shield of the State Medical Society, declared that the total premium income in the period from December 1946 to June 1950 was $2,846,323 of which $2,092,462 had been paid in benefits.

He also reported that the plan has reserves totaling $289,565. This amount is distributed as follows: maternity reserves, $97,020; reserves for disaster claims $45,532; unforeseen contingencies $116,582 and an administration reserve of $30,431.

The recently developed surgical-maternity contract is now being sold by Blue Cross agents, according to Dr. Dessloch. This is a basic protection contract which excludes x-ray, anesthesiology and medical care benefits.

It is being sold at a premium rate of 75 cents per month for an individual policy and $2.25 per month for a family policy. The same full payment features apply to income levels of $2,000 and $3,600.

Polio Advisory Group Gets Council Approval

Madison, Sept. 1.—Permanent status as a Council committee has been granted to the Advisory Committee to the Wisconsin Chapter of the National Foundation for Infantile Paralysis.

The committee had been appointed by President Truitt to draw up procedures for the selection of panels of physicians who could act as consultants in confirming diagnoses of polio.

Dr. H. W. Wirka, Madison, is chairman of the committee. Other members are Drs. K. B. McDonough, Madison; R. F. Poser, Columbus; M. H. Steen, Oshkosh, and R. S. Baldwin, Marshfield.

The Council suggested that two or three additional appointments be made from the lake shore region (Kenosha–Racine–Milwaukee).

Juneau County Society Backs Blood Program

Mauston, Aug. 31.—The Juneau County Medical Society is unanimously supporting the Red Cross blood program about to be launched there, according to Dr. J. S. Hess, Jr., Mauston, president.

In a letter explaining the medical society's position, Dr. Hess said, "The medical society endorses this program 100% as do all the other doctors in this territory. We would like to see our quota of 150 points collected soon."

He pointed out that the blood program has been instituted by the AMA, AHA, Catholic Hospital Association and others, with Red Cross in charge of the project.

Doctors Get One-Third of Health Care Money

Madison, Sept. 12.—A government survey shows that only about one-third of all money spent for health purposes goes to physicians in payment for their services.

The report, covering 1949, says that about 1.2 per cent of all money spent by American families for consumer goods and services goes to doctors of medicine. On the other hand, 2.06 per cent of the total goes for other health expenses.

During the 12 months, physicians received $2,267,000,000. During the same period Americans were spending $1,391,000,000 on drugs, $105,000,000 on private nurses, $416,000,000 on ophthalmic products and orthopedic appliances and $1,631,000,000 on private hospitals.

Doctors Asked to Help Find Hidden Diabetics

Madison, Sept. 11.—A new drive to uncover hidden cases of diabetes will get under way November 12–18 as part of National Diabetes Week. It is sponsored by the American Diabetes Association and has the support and approval of the American Medical Association.

Ask Medical Help

Plans call for the utilization of mass screening, self-testing and family-doctor-testing methods in a drive aimed at uncovering many of the estimate 1,000,000 hidden diabetics in United States.

The American Diabetes association urges every county medical society to cooperate in supporting the drive during Nov. 12–18. Mass screening of employees in industry and business will require the help of many physicians. Each society is urged to work out the method it would like to use for screening.

AMA Approves

At the AMA meeting in San Francisco last June, the house of delegates gave its approval to self-testing techniques for diabetes diagnosis. But officers of the diabetes association urge that patients see their own family physician for diabetes tests. Effective detection work by family physicians in their daily practices will, in the long run, prove the most satisfactory method of discovering new diabetes cases.

In the event a county medical society wishes to conduct a widespread campaign, testing materials may be obtained free of charge from the American Diabetes Association, 11 West 42nd Street, New York 18, New York.

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HEARING PROGRAM HAS REMARKABLE GROWTH

All Patients Referred to Family Doctors, Says SMS Committee

A program to bring help to the thousands of children in Wisconsin who have ears that can't hear is achieving remarkable success, according to the Committee on Hearing Defects of the State Medical Society.

During the past year more than 147,000 school children were tested for hearing loss, nearly 8,000 received careful rechecks through audiometer readings, over 2,000 were examined by otologists at special clinics and started on a sound program of rehabilitation through their family physicians.

Screen 150,000 Children

All this has come about through the joint efforts of the State Board of Health, the Bureau of Handicapped Children, the Committee on Hearing Defects of the State Medical Society, and outstanding cooperation on the part of teachers and parents throughout Wisconsin.

The Committee on Hearing Defects assists both state departments with medical aspects of the program, correlates practices and evaluates results. Its members are Doctors T. L. Tolan, chairman, and W. E. Grove, Milwaukee, and G. B. Ridout, La Crosse.

During the three years that this committee has advised the state departments Wisconsin's hearing program has developed far beyond the scope of screening surveys, which is often as far as such public health projects go.

In 1947 hearing programs were being conducted in only 6 counties. By 1950 the programs had been expanded so that 41 counties were being served and 12 more counties indicate a desire to participate next year. Only a lack of skilled personnel holds back its further expansion.

Nearly 150,000 children are screened each year and nearly 2,000 of these are started on treatment or rehabilitation programs.

But the most significant part of the Wisconsin program is not the extensive testing done or the number of children given audiometric studies, according to Doctor Tolan.

EXTENT OF HEARING PROGRAM IN 1947

It is the successful operation of the otologic clinics and the care taken by the specialists rendering this service to refer the patient back to the family physician for continued study.

As a result of the policies laid down by the Committee on Hearing Defects, Doctor Tolan declares, the operation of the otologic clinics retains rather than destroys the patient-family physician relationship often endangered by programs of this type.

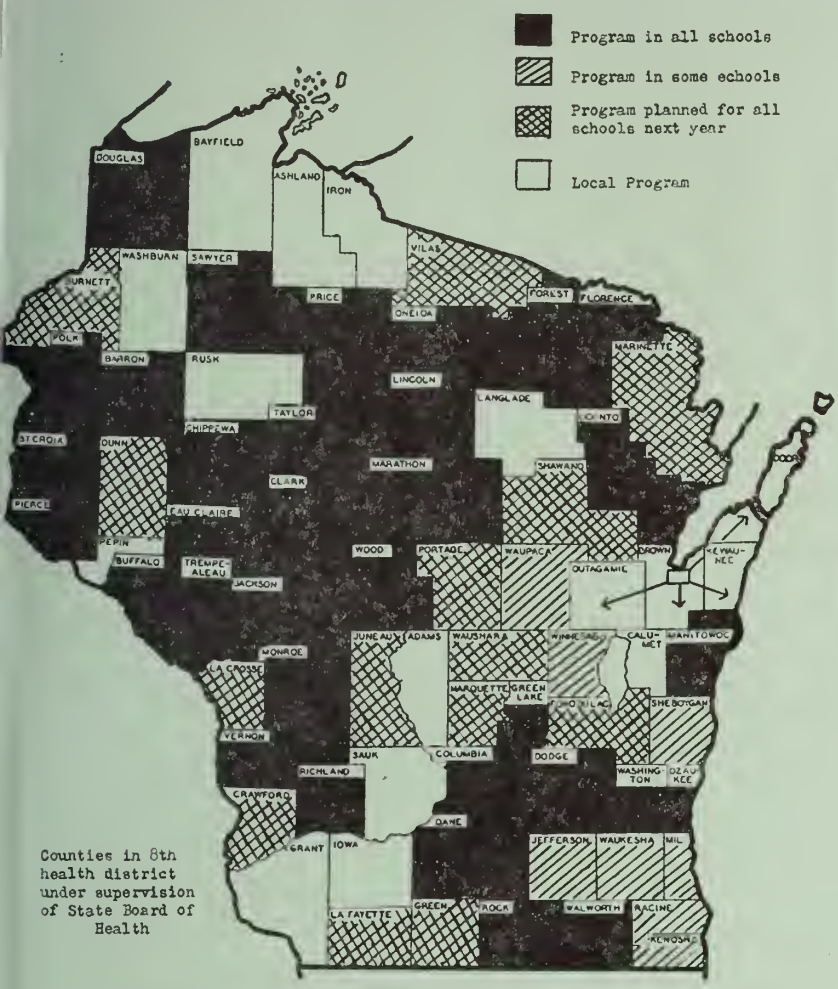
The Wisconsin program aims to educate the citizens in the problems of hearing and is built around parent–teacher–community–professional cooperation.

First, teachers and parents trained in the use of the audiometer conduct simply screening tests on all school children in the locality. Skeptics said that lay persons couldn't do this job satisfactorily. Experience shows that the laymen charged with the responsibility of initial screening are extremely conscientious and, if anything, err on the side of caution in evaluating the need for further study by medical personnel.

Doctor Tolan places high value on this lay participation and adds that they save a lot of time for physicians and nurses.

All children who fail to meet the passing standard set for the screening test are then rechecked by a person carefully trained in audiometric work. Slightly more than 5 per cent of those screened were rechecked in 1949–50 program.

About one-third of all children retested by audiometer experts were then examined by medical



Counties in 8th health district under supervision of State Board of Health

EXTENT OF HEARING PROGRAM IN 1950

specialists at otologic clinics held in the area.

The medical examiners, all members of the Board of Otolaryngology, are selected by the county medical society in which the clinic is conducted. If the specialists' examinations indicate further study and a treatment or rehabilitation program the patient is referred back to the family doctor.

Although the hearing program has developed rapidly among the children attending Wisconsin's public and parochial schools, the Committee on Hearing Defects is not content with the present status of the project and plans continuing studies to make sure that the person served feels everything possible has been done for his benefit and to determine what real progress is being made in rehabilitation.

And despite the dramatic progress of the hearing conservation program, the committee reports that some physicians in certain areas of the state are inclined to view the work of the two state departments as a form of socialized medicine.

Doctor Tolan emphasized that there is little danger that the program will lead to federalized medicine since both programs are under the guidance of the profession, established and maintained on the basis of local responsibility, and operated so that after several years of operation they will be carried on without state and federal support.

The fact remains that more and more physicians and communities are accepting the program as a boon to child development. It is eradicating the "hush-hush" attitude toward the hard of hearing and promises to have significant effects upon individual personalities, family morale, and community mental health.

BIG GAINS IN VOLUNTARY PLANS

Madison, Sept. 13.—Big gains in voluntary health insurance during the last year have been reported by the Health Insurance Council, made up of leading associations in the life and casualty insurance fields.

Most important of the 1949 gains were those in the surgical and medical expense protection for individuals and families.

At the end of the year, 44 per cent of the entire population was covered by hospitalization insurance, and nearly 60 per cent of the employed civilian population was protected against loss of income because of disability.

Persons covered under voluntary plans for hospital expense increased to 66,044,000 (a jump of 5 million), surgical coverage increased to 41,143,000 (a rise of 7 million), medical expense coverage increase from 13,000,000 to 17,000,000, and coverage for loss of income because of illness or accident rose from 33,410,000 to 34,136,000.

Uncle Sam Has Record Month with New Hospitals

Washington, D. C., Sept. 12.—September promises to be a record month in increasing Uncle Sam's stature as a hospital administrator.

Although government officials admittedly have their fingers crossed in the matter of adequate professional staffing, nevertheless six more veterans hospitals (1,450 beds) are to go in commission this month and perhaps three times as many military hospitals will be taken out of mothball status.

On top of all this, schedules call for six more VA hospitals to be opened in the final quarter of 1950 with a total of 2,075 beds. And the Navy says its $14,000,000 facility on Long Island will open three months ahead of schedule, and the VA has just let the bid for a $12 million 750-bed institution in Pittsburgh.

Continuing expansion of military hospital facilities brings the question of care of servicemen's dependents into sharp focus, and a special report on the subject is expected any day in the House.

School Health Committee Gets Permanent Status

Madison, Sept. 1.—The Committee on School Health, appointed by President Truitt for a term of one year, has been given permanent status by being designated as a Council Committee.

The action was taken at the August 19–20 meeting of the Council.

The committee is composed of Drs. F. J. Mellencamp, chairman, Milwaukee; E. B. Pfefferkorn, Oshkosh; W. R. Manz, Eau Claire; Amy Louise Hunter, Madison, and A. C. Edwards, Racine.

Three ex-officio members also serve on the committee: the director of public health nursing of the State Board of Health (Miss Janet Jennings); the health educator of the Department of Public Instruction (Mr. Orlo Miller), and the health educator of the State Board of Health (Mrs. Catherine Campbell).

The Committee serves as an advisory committee to both the Department of Public Instruction and the State Board of Health in their activities in school health.

A school administrator, currently Mr. George Watson, superintendent of the Department of Public Instruction, also serves in an ex-officio capacity.

Dr. J. J. Waring

DENTISTS START POST-PAY PROGRAM

Milwaukee, Sept. 1.—A dental payment plan has been initiated by the Wisconsin State Dental Society to enable dental patients to obtain dental work costing $100 or more on a time-credit basis.

This post-payment plan for dental care permits patients to spread the cost of dental services over periods as long as a year with payments on a monthly basis.

Amounts as low as $50 may be financed by special arrangement with local dental societies and a financing agency.

Two TB Physicians Speak on Dearholt Days

Drs. Waring and Maier Talk at Madison, Milwaukee

Madison, Sept. 11.—Medical students from two Wisconsin universities and the Dane County Medical Society will hear two noted tuberculosis physicians in November, when the Wisconsin Anti-Tuberculosis Association (WATA) observes "Dearholt Days."

The speakers will be Dr. James J. Waring, professor of medicine at the University of Colorado, and Dr. Herbert C. Maier, assistant clinical professor of thoracic surgery at the Post-Graduate Medical School of the New York University–Bellevue Medical Center.

They will address medical students at Marquette University in Milwaukee on Monday, Nov. 20, and at the University of Wisconsin in Madison on Tuesday afternoon, Nov. 21. They will speak before the Dane County Medical Society Tuesday evening.

Dearholt Days are observed annually in honor of Dr. Hoyt E. Dearholt, founder of the WATA, who died in 1939.

Wisconsin Plan Enrolment Nears 250,000; Committee Reviews Experience of 4 Years

Madison, Sept. 13.—Enrollment in the Wisconsin Plan of prepaid surgical, obstetrical and hospital insurance reached a new high of 249,783 persons at the end of June, reports Dr. Robert Krohn, Black River Falls, chairman of the Wisconsin Plan Committee.

In a review of Wisconsin Plan progress since it began operation in April 1946, Dr. Krohn pointed out that its first two years were experimental and sales and insurance carrier participation were restricted.

However, by June 1948, enrollment had reached 123,000 and 83 per cent of $2,000,000 in premium collections had been returned by way of benefit payments.

As of June 30, 1949, the Wisconsin Plan Committee estimated total enrollment, including dependents, as 211,500. Total premium collections by insurance carriers, from the date each company entered the plan, was about $4,142,000.

Benefits to this date totaled 83 per cent of the premiums and administrative expenses were estimated as 22 per cent. Thus there was an actual loss to all insurance carriers since 1946 of about 5 per cent.

A major reason for the high utilization is that home and office surgery is recognized along with that done in hospitals.

Upon the advice of the Society's consulting actuary, administrative costs have not been obtained for 1950, because records are maintained on a fiscal year basis.

Dr. Krohn emphasized that enrollment figures should be viewed in light of the fact that insurance carriers have marked time for a good share of 1950 awaiting the State Medical Society's decision on a schedule of benefits.

This schedule has now been cleared, policies have been reprinted and the schedule distributed.

Public Representation on Prepaid Plan Committee Given Council Okay

Madison, Sept. 1.—A proposal for the formation of an Advisory Commission on Prepaid Health Plans in Wisconsin to be composed of representatives of the public and allied professional interests, was approved by the Council of the State Medical Society at its August 19–20 meeting.

The recommendation came out out of the Coordinating Committee of Prepaid Health Plans, Dr. H. E. Kasten, Beloit, chairman. It suggested that such an advisory commission meet periodically to view the Society-sponsored health programs in whatever manner the Commission might determine.

The commission would act in an advisory and persuasive capacity to either the Wisconsin Plan or Blue Shield, and would report to the Council, probably through the Coordinating Committee.

The Council asked that the Coordinating Committee complete development of the plan and report at a later date.

. . . . THE PRESIDENT'S PAGE . . . .

Swan Song

THANKS for everything. For the honor and privilege of being your president for the past year. For the hearty cooperation and well meant constructive criticism from each and every one of you. For the unselfish time and long continued efforts of the chairmen and members of the various committees. For the privilege of continuing and sparking Dr. Karl Doege's project of obtaining group health and accident insurance for the members of the State Medical Society of Wisconsin. For the determination of the committee headed by Dr. Maurice Hardgrove in finishing the project of health and accident insurance. For the cooperation and hard work of the Society's attorney, Robert Murphy. For the wisdom shown by the Council in giving this project full support after the House of Delegates gave it the green light. For the dignified and gentlemanly way the Committee on Grievances has conducted itself both toward laymen and doctors with a full and impartial investigation of every complaint referred to it and firm judgment whenever and wherever it was justified. For the consideration at all times of the Council members toward the president's suggestions and efforts in obtaining unity, peace, and forward progress in the problems which confront the citizens of the United States, of which the doctors must be a moving force.

For the hard work of the prepaid plan committees and their efforts to keep the Council informed of their various problems. For the veterans committee's home town program and its educational program showing the veteran that the medical profession can and will give him care the American way. For the interesting program the Council on Scientific Work has worked long and hard to furnish the Society members this October. For the time and thought given by the other various committees and individual members by whose efforts this State Medical Society of Wisconsin has a place well toward the front of all medical societies of these United States. For the devotion and loyalty and tireless energy of the personnel of the State office. For its systematic way of doing business. For its full reporting of various meetings and a printed budget. For all the members of the Council, Interim Committee, and, last but not least, for your incoming president, Chris. With him as your Head, we will have a forceful year and my small project to be studied and considered—group malpractice insurance.

John Wm Truitt MD

Report of the Committee on Maternal and Child Welfare of the State Medical Society, Including Analysis of Hospital Data

THE function of the Committee on Maternal and Child Welfare of the State Medical Society is to help in clarifying, for physicians, state problems and means for improving maternal and child health services. The committee also acts in an advisory capacity to the Bureau of Maternal and Child Health of the State Board of Health. It reviews new plans and projects as well as recent trends and special problems as they arise each year. It makes suggestions and reports to the House of Delegates of the State Medical Society.

Fully recognizing that by far the largest share of obstetric and pediatric care in Wisconsin is rendered by the general practitioner, the committee feels a special responsibility to all Wisconsin physicians. Questionnaires are a tangible means of clarifying problems and interpreting needs of local areas. Following the spring committee meeting, therefore, questionnaires were sent to all hospitals in Wisconsin.

Returns were received from 123 hospitals. The data from these have been summarized and are presented for review. It is regretted that information was not received from 15 hospitals representing approximately 788 beds, of which 192 are listed for maternity services. The group returning the questionnaires represented hospitals caring for approximately 85 per cent of the 82,736 Wisconsin livebirths in 1949. The maternity beds totalled 2,083. Of the smaller hospitals, a number had but 2 or 3 beds; yet some of these delivered 100 or more maternity patients. The largest had 85 beds and delivered 3,856 patients. In striking contrast with available maternity beds was the very much more limited number of beds available for pediatric patients. The potential Wisconsin population estimate of children under 20 for 1949 was approximately 1,150,000 (infants 80,540; preschool 291,448; school age 778,000). Wisconsin has but one children's hospital, which is in Milwaukee. In the 123 hospitals covered in the report there was a total of 11,752 beds but only 847 (7.2 per cent) were designated for children.

In contrast to facilities reported a few years ago, it was encouraging that all but 2 of the 123 hospitals had one or more incubators available for care of premature babies. Nearly 50 per cent of the hospitals indicated that they had staff nurses with some training or experience in care of the premature infants. Fourteen hospitals wished nurses to obtain more special training. Nine of the hospitals whose nurses had special premature training had received stipends provided by the State Board of Health.

Unfortunately, for 45 (36 per cent) of the hospitals information on fate of premature infants by weight group was not supplied. Consequently, data are available only for 2,269 premature babies. Of these 1,755 (77.3 per cent) survived and 514 died (22.7 per cent). State figures for 1949 based on total premature births by gestation show 5,409 premature babies. Among the infants that died, there were 1,149 prematures (21.2 per cent). These are not directly comparable with the hospital data, which deal only with the neonatal period. Beginning in 1950, premature births and deaths by weight can be analyzed for the state. In the meantime the experience of the hospitals reporting is the only data available for review of immediate survival experience by weight for premature babies:

	Weight	*Births*	*Deaths*	
Prematures	Under 3 pounds	294	234, or	79.6 per cent
Hospitals	3 to 4 pounds	411	151, or	36.7 per cent
Reporting	Over 4 pounds	1,564	129, or	8.2 per cent
		2,269	514	22.7

There is evidence of real need for paying more attention to the stillbirths which occur in the state, especially in certain hospitals. The total Wisconsin resident rate for stillbirths was 15.4 per thousand livebirths. The over-all rate as shown for the hospitals which filed these data was 14.6 per thousand livebirths. In contrast to this, however, there were 17 hospitals with rates of more than 20 per thousand livebirths. Broken down, the rates of 6 ranged from 20 to 24.9; 7 from 25 to 29.9; and 4 had rates of 30 or more. If each of these hospitals could reduce its rate to the state level, very marked progress would be shown. For further study it will be important to know the weight of all babies, whether they are liveborn or stillborn. In this way, factors that may influence the outcome of delivery can be related to the prenatal history of the mother, hospital procedures, and the care available for the baby.

Many more hospitals than a few years ago have facilities for postmortem examinations, but relatively few are routinely performing autopsies in cases of maternal and infant deaths.

Within recent years an unusual amount of lay publicity has been given to recognition of pregnancy and delivery as a natural physiologic process. Much of this publicity has been stimulated by Doctor Read's book, "Childbirth Without Fear". There has also been an increased interest in "rooming-in" fol-

Infant and Maternal Deaths—State of Wisconsin

1950	1943	1944	1945	1946	1947	1948	1949
Population	3,137,587	3,137,587	3,137,587	3,162,606	3,213,435	3,246,000	3,354,000
Total Live Births	64,250	61,025	60,839	74,144	83,907	81,300	82,736
Rate per 1000 pop.	20.5	19.4	19.4	23.4	26.1	25.0	24.7
Premature births	3,254	3,226	3,108	4,035	4,842	4,688	5,409
% Total Live births	5.1%	5.3%	5.1%	5.4%	5.8%	5.8%	6.5%
Total Stillbirths	1,306	1,184	1,141	1,300	1,410	1,357	1,274
Stillbirth Rate (Per 1000 live births)	20.3	19.4	18.8	17.5	16.8	16.7	15.4
Total Infant Deaths	2,224	1,950	1,890	2,235	2,470	2,147	2,193
Infant Death Rate (Per 1000 live births)	34.6	32.0	31.1	30.1	29.4	26.4	26.5
Neonatal Deaths (Under one month)	1,483	1,301	1,302	1,648	1,870	1,596	1,596
% total infant deaths	66.7%	66.7%	68.9%	73.7%	75.7%	74.3%	72.8%
Neonatal Death Rate (Per 1000 live births	23.1	21.3	21.4	22.2	22.3	19.6	19.3
***Deaths assigned to "Premature birth"**	719	625	647	808	946	787	590
% total infant deaths	32.3%	32.1%	34.2%	36.2%	38.3%	36.7%	26.9%
Maternal Deaths	126	113	81	101	87	83	47
Maternal Death Rate (Per 1000 live births)	2.0	1.9	1.3	1.4	1.04	1.02	0.6
Home Deliveries (% total deliveries)	16.7%	12.2%	8.9%	6.3%	4.6%	3.7%	3.0%

*Many death reports show prematurity as the only cause of death. Every effort should be made to determine a more specific diagnosis.

lowing the reports from Yale University. This committee was uncertain about expressing any opinion in regard to these present day trends because in most instances hospitals are not adequately planned to provide "rooming-in" services, and physicians' time is too limited to train patients in Doctor Read's method. However, the hospital questionnaire revealed that popular demand has increased to such an extent that 20 per cent of the hospitals in the state have had requests for the application of Doctor Read's "Childbirth Without Fear" technique. As to rooming-in, 8 hospitals reported that they could offer this service and had had 88 patients. Present demand has already resulted in special attention to study groups and patient reading by 19.5 per cent of the hospitals. Exercise training for relaxation was in use by some doctors serving 17 per cent of the hospitals. Perhaps the experience in New York and elsewhere in the use of well planned group teaching may bridge the gap and provide wiser use of physicians' time. Self-demand schedules have been adopted to some extent in 17.8 per cent of the total.

Most physicians are advocating early ambulation when there is no contraindication. In 40 hospitals some patients were up on the first day; while in 35 hospitals ambulation began for some on the second day; and in 27 hospitals on the third day postpartum. In only 16 hospitals were patients routinely kept in bed four or more days. The majority of patients are discharged from the hospital on the fifth day or later.

It seems wise to point out that early ambulation should not necessarily mean early discharge. For example, in the Chicago Lying-In Hospital, although the patients are up on the first or second day, they usually are released on the tenth day. During the period of hospital stay the nurses do intensive educational work with the mothers, who provide a good deal of the care for their babies. Contrary to the expressed opinion before this plan was well under way, it was found that a larger nursing staff was not needed. The nurses, by having many of their routine procedures taken over by the mothers, had time to teach the mothers and demonstrate care.

There seemed to be very little planned use of community nursing facilities for follow-up on obstetric patients when they left the hospital. Twenty hospitals indicated that primiparas were sometimes referred to the Visiting Nurses Associations or public health nurses. Sixteen additional hospitals referred only mothers of premature infants. It was also indicated that, although some hospitals demonstrated bathing care, relatively little was done to send the mother home from the hospital with experience and understanding of caring for her new baby. This would indicate the need for prenatal and postnatal classes as now conducted in some localities under competent sponsorship. The State Board of Health, Bureau of Maternal and Child Health, has material, teaching aids, and outlines available for this purpose.

From the hospital experience but 9 cases of retrolental fibroplasia were reported. It is possible that this is a total and not the year's experience. With the increase in survival rate of the very small premature babies, it becomes increasingly important that doctors everywhere in the state routinely observe the very immature group of premature infants routinely after birth.

The following specific recommendations are made by the committee:

1. The committee recommends that each hospital staff constantly appraise its own experience on maternal and infant mortality, morbidity, stillbirths, and premature infants. This can be done through staff discussions, consultations, and extention of postmortem examinations wherever practical.

2. Hospital staffs should continue to require consultation prior to operative delivery.

3. Every effort should be made to reduce premature deliveries. At the same time hospitals should have adequate facilities and nurses with special training in care of premature infants.

4. Increased effort should be made to make special provisions within hospitals for more pediatric beds and nurses with special training in pediatrics wherever the service so justifies.

5. Each newborn infant, including prematures, should be considered as an individual patient and the physician should take full responsibility for its care. There should be careful medical appraisal based upon examination of baby after delivery and before discharge from hospital, including routine examination of premature babies for evidence of eye changes in the months immediately after birth.

6. Some attempt should be made to appraise the need for meeting public demand for rooming-in and "childbirth without fear," with possible consideration of the use of group teaching for prenatal patients based on plans worked out cooperatively with physicians.

7. Hospitals should assume more responsibility for orienting parents to the care of their babies while they are in the hospital. This should be augmented by referral to community nursing groups, either the Visiting Nurses Association or public health nurses, especially for first born infants and babies born prematurely.

8. As a means of better appraisal of the problems of prematurity every baby should be carefully weighed immediately after birth, whether liveborn or stillborn. In every instance, efforts should be made to determine the cause of prematurity and in event of stillborns, autopsies should be conducted as often as possible. Diagnosis should be carefully reported on death certificates.

9. Doctors should give support through participation in any planned program in obstetrics and pediatrics organized through the State Board of Health and the State Medical Society.

10. The new trends in providing care for children should be adopted in as far as possible, including recognition of emotional influences. Self-demand schedules might be considered where possible.

11. Doctors should exert their influence in establishing hospital policies which will encourage breast feeding and give the mother adequate education and encouragement for continuance of nursing after release from the hospital.

12. Greater effort for careful completion of birth and death certificates so that fewer queries will be necessary. It is especially important to be sure that the sequence on maternal death certificates clearly shows whether pregnancy is responsible for deaths.

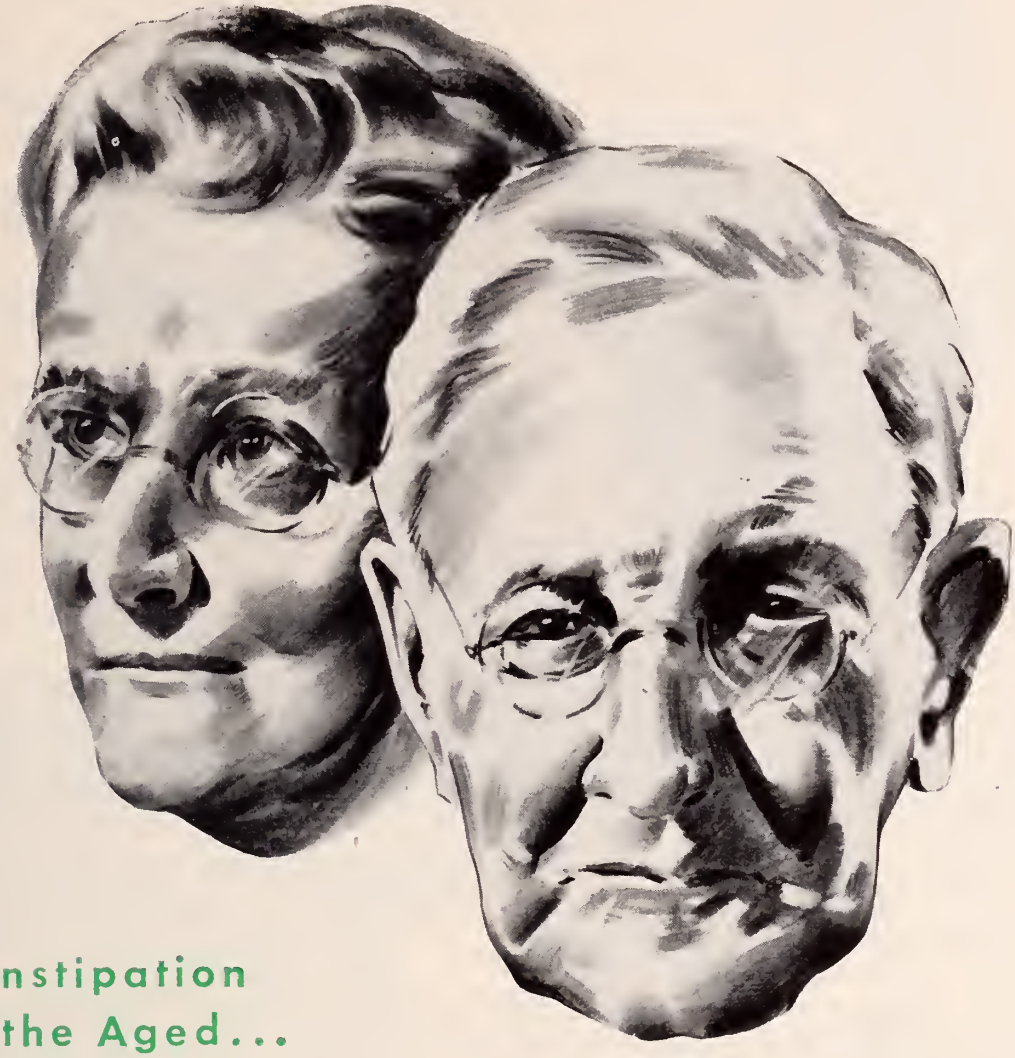
UNIVERSITY OF MINNESOTA ANNOUNCES CONTINUATION COURSES

The University of Minnesota announces a continuation course for physicians on cortisone and ACTH to be presented at the Center for Continuation Study on October 4, 1950.

Subject matter for the course will include pituitary adrenal inter-relationships, the alarm reaction, and tests of adrenal cortical function. The use of cortisone and ACTH in allergic states, rheumatic fever, rheumatoid disease, and eye disorders will highlight the therapeutic section of the course.

Faculty for the course will include members of the staffs of the Mayo Clinic and the University of Minnesota Medical School.

A continuation course for physicians in Diseases of the Chest will be presented at the University of Minnesota Center for Continuation Study on October 26–28. The course is intended for general physicians and is presented with the sponsorship and financial support of the Minnesota Trudeau Society. Distinguished visiting physicians who will participate as faculty members of the course include Dr. O. A. Sander, associate in medicine, Marquette University School of Medicine; Dr. John H. Skavlem, president of the American Trudeau Society and associate professor of medicine, Cincinnati University Medical School; and Dr. James J. Waring, professor and chief of medicine, University of Colorado. The remainder of the faculty for the course will be made up of members of the staff of the University of Minnesota, the Mayo Foundation, and the Minnesota Trudeau Society.



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Society Proceedings

Calumet

Meeting at the Hotel Chilton in Chilton on July 25, members of the Calumet County Medical Society discussed the small pox inoculation which will be given to all school children in the county. *Dr. J. J. Minahan,* Chilton, was appointed medical advisor of the Auxiliary, which also met that evening at the Hotel Chilton.

Crawford

The Crawford County Medical Society held a dinner meeting at Kaber's Nite Club, Prairie du Chien, on August 16.

Vernon

Members of the Vernon County Medical Society met on August 9 at Martha's Cafe in La Farge. *Dr. P. C. Dietz,* pathologist at the St. Francis Hospital, La Crosse, gave a talk on new laboratory tests for cancer.

Wood

Dr. N. J. Helland, Marshfield urologist, was the principal speaker at a meeting of the Wood County Medical Society at the Golden Gate near Wisconsin Rapids on August 3. Doctor Helland's subject was "Wilms' Tumor in Children," and he pointed out that early diagnosis of the disease is vital for recovery of the patient.

American Academy of General Practice Sheboygan Chapter

A dinner meeting of the Sheboygan chapter of the American Academy of General Practice was held at Miller's Guest House at Plymouth on August 3. Guest speaker was *Dr. E. A. Bachhuber,* assistant dean of Marquette University School of Medicine, Milwaukee, who talked on "Liver Function Tests in Relation to Surgery." Lantern slides were used to illustrate his discussion. A business meeting followed.

American Academy of General Practice Rock County Chapter

Dr. O. V. Overton, Janesville, was elected to head the Rock County Chapter of the American Academy of General Practice at an organizational meeting held at the Cozy Inn, Janesville, on August 3. Serving with Doctor Overton will be *Drs. C. M. Carney,* Beloit, vice-president, and *Thomas Sweeney,* Beloit, secretary. *Dr. O. S. Orth,* professor of pharmacology at the University of Wisconsin Medical School, was the guest speaker. Other guests at the meeting included officers of the Dane County chapter of the Academy, and *Drs. George E. Forkin* and *William B. Hildebrand* of Menasha, president and secretary respectively of the Wisconsin chapter of the Academy.

Seventh Councilor District

Meeting at the La Crosse Country Club on August 22, members of the Seventh Councilor District Medical Society heard talks by two members of the staff of the Mayo Clinic, Rochester, Minn. Dr. Waltman Walters discussed "Peptic Ulcers," and Dr. L. E. Ward spoke on "Arthritis." Dr. R. L. MacCornack, Whitehall, president of the seventh district, presided at the meeting.

Ninth Councilor District

The Ninth Councilor District Medical Society held a dinner meeting at the Wausau Club, Wausau, on August 17. Dr. Herbert E. Schmitz, Chicago, was the guest speaker, discussing "Gynecological Malignancies." Dr. Maurice Rice, Stevens Point, is the president of the organization.

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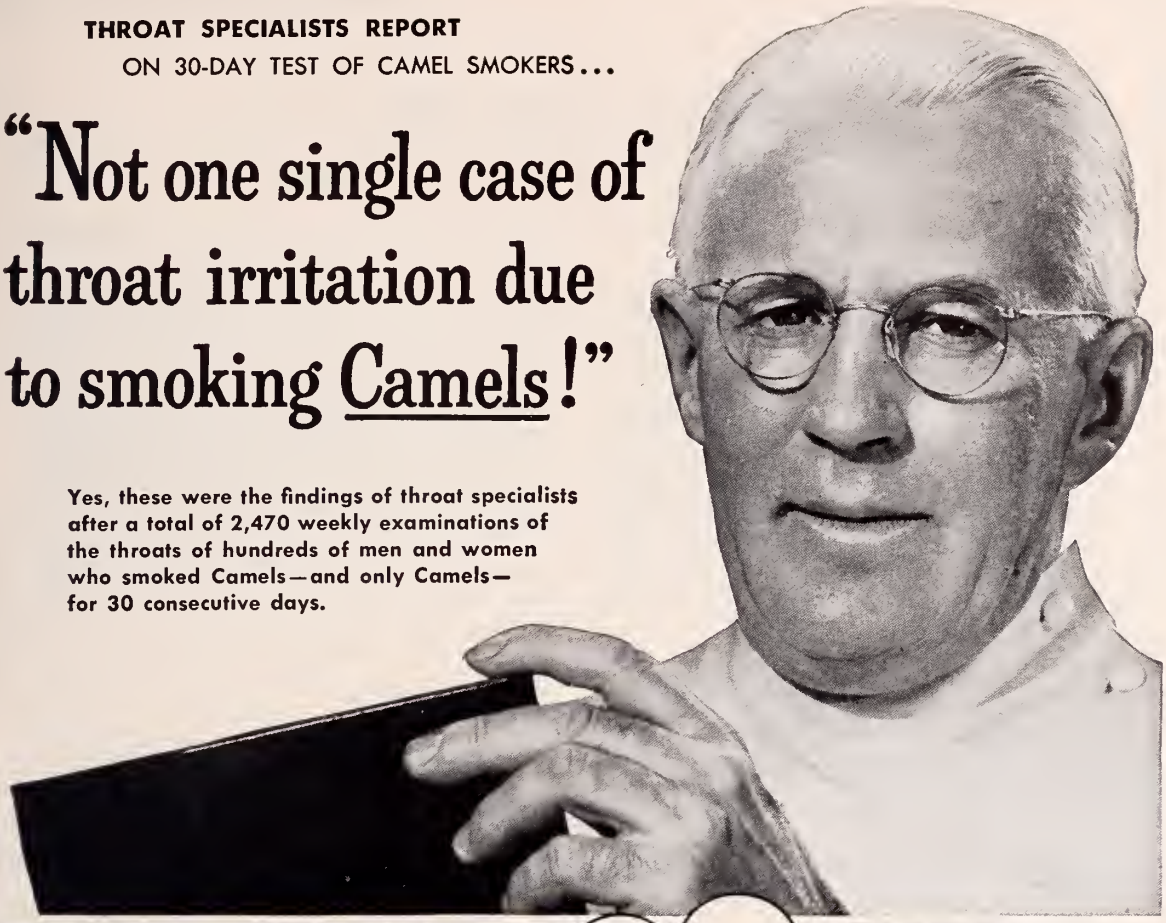

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News Items and Personals

Boscobel Physician Honored For Half Century of Service

Over 500 residents of the Boscobel area attended a ceremony in the community on August 17 to pay tribute to *Dr. Charles S. Hayman*, practitioner in that community for fifty-five years. A member of the Fifty Year Club of the State Medical Society, the doctor came to Boscobel in 1895, following graduation from Rush Medical College, Chicago. Speakers at the ceremony, which was sponsored by the Boscobel Chamber of Commerce, included representatives of the business men, the Kiwanis Club, Eagles Club, and medical profession. The doctor was presented a watch and a traveling bag. A reception in Blaine gymnasium followed the ceremony, and the Grant County Medical Society honored him at a dinner at the Boscobel Hotel in the evening.

Doctor Hayman, a charter member and former president of the Grant County Medical Society, has been active in civic affairs as well as in the medical field. Until 1946 he was a member of the Boscobel Clinic.

Dr. E. C. Cary Attends Carnegie Club Convention

Dr. E. C. Cary, Reedsville, attended the first international convention of the Dale Carnegie Club International held at the Palmer House in Chicago, June 24 and 25 as a delegate from the Manitowoc Chapter. He had the honor of being the first one at the convention to register. Delegates were present from all over the United States and Canada and there was also one from Hawaii.

Former Amherst Physician Joins Staff at Mendota Hospital

Dr. George M. Schlenker, formerly of Amherst, recently became a member of the psychiatric staff of Mendota State Hospital, Madison. The doctor served in the Army Medical Corps during World War II and practiced at Amherst for one and one-half years before beginning a residency in psychiatry at the State of Wisconsin General Hospital.

Berlin Physician Begins Postgraduate Course

Dr. L. J. Seward, Berlin, left on September 1 for Los Angeles, where he will enroll in a nine months' postgraduate course in general surgery at the College of Medical Evangelists. The doctor, who served in the Army Medical Corps during World War II, returned to his practice in Berlin in 1945.

Dr. Raymond Evers Addresses Sheboygan Rotary Club

Dr. Raymond Evers, superintendent of Rocky Knoll Sanatorium, Plymouth, addressed the Sheboygan Rotary Club on July 24. His topic was the "Use of BCG Vaccine in the Prevention of Tuberculosis."

Waupun Physician Has New Associate

Dr. James M. Sinnett, formerly of Spencer, W. Va., recently joined *Dr. J. P. Semmens*, Waupun, in the practice in medicine. Doctor Sinnett, who has been on Navy duty for two years, was stationed in the Panama Canal Zone this past year. He received his degree from Temple University School of Medicine, Philadelphia.

Fond du Lac YMCA Votes Resolution to Late Doctor

The board of directors of the Fond du Lac YMCA at a recent meeting passed a resolution honoring the late *Dr. Ernest V. Smith* of that city. The doctor, for many years a member of the board of trustees, was associated with the board of directors from 1939 to 1947 and served as president in 1941 and 1942. The board officially expressed "deep appreciation for the contributions he has made to the work of the Young Men's Christian Association and our sincere sympathy to his family and friends."

Dr. L. J. Weller Addresses Public Health Council

Dr. L. J. Weller, Osceola, president of the Polk County Medical Society, spoke before the Polk County Public Health Council at Balsam Lake on July 27. He discussed the symptoms of diabetes and pointed out that the disease can be controlled with proper care.

V. A. Names New Manager of Tomah Hospital

Dr. Joseph B. Bounds, formerly chief of the professional services of the Veterans Hospital, North Little Rock, Ark., was recently appointed manager of the Veterans Administration Hospital at Tomah. He succeeds Dr. George D. Rice, who retired from V.A. service on August 31. Doctor Bounds is a diplomate of the American Board of Psychiatry and Neurology and has served with the Veterans Administration since 1939.

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"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. O. A. Stiennon Associates With Madison Radiologist

Dr. O. Arthur Stiennon recently became associated with *Dr. Lawrence V. Littig*, Madison, in the practice of radiology. A diplomate of the American Board of Radiology, the doctor served a residency at the University of Michigan Medical School. He is a graduate of the University of Wisconsin Medical School and served in the Army Medical Corps from 1944 to 1947.

Dr. W. V. Luetke Begins Obstetric Practice in Madison

W. V. LUETKE

Dr. William V. Luetke, who recently completed a residency in obstetrics and gynecology at the State of Wisconsin General Hospital, opened an office in Madison for practice in his specialty on August 28. He will serve on the staffs of St. Mary's and Madison General hospitals. A graduate of the University of Wisconsin Medical School, the doctor served in the United States Navy during World War II.

Madison Physician Addresses Oklahoma Meeting

Dr. J. W. Gale, professor of surgery at the University of Wisconsin Medical School, was a guest speaker at the annual meeting of the Oklahoma State Medical Society held in Oklahoma City, June 5–7. He presented papers on "Carcinoma of the Lung" and "The Crippled Lung" and conducted a round table on "Thoracic Diseases."

Dr. Maxine Bennett to Serve in State Bureau

Dr. Maxine Bennett, Madison, was appointed on August 9 to serve as medical specialist in the State Bureau for Handicapped Children. Doctor Bennett will serve with Mr. Frank Powell, assistant superintendent of the Bureau in interpreting good medical practices to educators. Doctor Bennett, the first physician to be employed by the department, will continue her work as a part time teacher in the department of otolaryngology at the University of Wisconsin Medical School.

Madison Physician Attends Meeting of Neurologists

Dr. Mabel G. Masten attended meetings of the American Association of Neuropathologists and the American Neurological Association in Atlantic City, N. J., June 11–14. While in Atlantic City, she also attended a symposium on the temporal lobe given by the American Association of Electroencephalographers. At the convention of the American Medical Association in San Francisco in June, she was elected vice-chairman of the Section on Nervous and Mental Disease.

Madison Dermotalogist Addresses Optimist Club

Dr. Garrett A. Cooper, Madison dermatologist, addressed a meeting of the Madison Optimist Club at the Madison YMCA on August 21. His subject was "Your Skin in Summer."

Dr. T. C. Erickson Addresses Neurologist Meeting

T. C. ERICKSON

Dr. T. C. Erickson, associate professor of surgery at the University of Wisconsin Medical School, attended a convention of the American Neurological Association at Atlantic City, N. J., June 11–14. He presented a paper entitled "Study of the Post Central Gyrus in Man by the Evoked Potential Technique" prepared in cooperation with Dr. C. N. Woolsey, and one on "Clinical Observations on Basilar Impression of the skull," written in cooperation with *Drs. L. W. Paul* and *Henry Suckle*.

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Two University Staff Members Serve as Resident Consultants in Washington D. C.

Drs. L. W. Paul and *D. Murray Angevine*, Madison, acted as consultants to the Armed Forces Institute of Pathology in Washington, D. C. for a period during June. Doctor Paul is professor of radiology and Doctor Angevine, professor of pathology at the University of Wisconsin Medical School.

SOCIETY RECORDS

New Members

A. A. Fretham, M. D., Nash Motor Company, Kenosha.

G. R. Weber, M. D., Kenosha Bank Building, Kenosha.

G. A. Benish, M. D., 46 North Main Street, Clintonville.

R. E. Bolinske, M. D., Box 267, Weyauwega.

D. P. Davis, M. D., Muirdale Sanatorium, Milwaukee.

D. J. Garland, M. D., Shullsburg.

J. J. Mueller, M. D., St. Michael's Hospital, Milwaukee.

R. F. Schilling, M. D., 1300 University Avenue, Madison.

T. P. Froehlke, M. D., New Lisbon.

Changes in Address

B. J. Mansheim, M. D., La Crosse, to 119 Finkbine Park, Iowa City, Iowa.

L. E. Coffin, M. D., Kenosha, 2826 East Kleindale Street, Winterhaven, Tucson, Arizona.

J. M. Meyer, M. D., Wood, to 161 West Wisconsin Avenue, Milwaukee.

Abe Adland, M. D., Minneapolis, to 3314 North 28th Place, Phoenix, Arizona.

W. E. Gilmore, M. D., Madison, to 809½ Market Street, Parkersburg, West Virginia.

E. L. Doermann, M. D., Madison, to 5536 Monroe Street, Sylvania, Ohio.

L. F. Bleyer, M. D., Madison, to 21 Peace Street, Providence, Rhode Island.

D. T. Long, M. D., Menomonie, to 1007 Monmouth Avenue, Durham, North Carolina.

T. J. Petrick, M. D., Milwaukee, to 2293½ Hillside Avenue, St. Paul, Minnesota.

J. D. Silbar, M. D., Milwaukee, to Wisconsin General Hospital, Madison.

John East, M. D., Duarte, California, to 1050 Twenty-second Street, Merced, California.

S. S. Bederman, M. D., Milwaukee, to 2610 Balmoral Street, Chicago, Illinois.

Louis Kohn, M. D., Milwaukee, to Plymouth.

J. N. Richards, M. D., Madison, to Cleveland City Hospital, Cleveland, Ohio.

R. H. Schmidt, Jr., M. D., Washington, D. C., to 808 Haycock Road, Falls Church, Virginia.

George Mohler, M. D., Mondovi, to 1109 Superior Avenue, Oconto.

Lt. (j.g.) Robert Merrill, Milwaukee, to Oaknoll Naval Hospital, Oakland, California.

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DEATHS

Dr. Roger Cahoon, 73, Baraboo physician, died at a Madison hospital on July 22. The doctor had practiced medicine in Baraboo for forty-eight years.

Doctor Cahoon was born on March 2, 1877. He received his M. D. degree from the University of Louisville School of Medicine, Louisville, Ky., in 1902 and began practice in Baraboo shortly afterward. He served on the staff of St. Mary's Ringling Hospital in that city.

Doctor Cahoon was a member of the Sauk County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife, a daughter, and a son.

Dr. John M. Dodd, widely known physician at Ashland for sixty years, died at a hospital in that city on August 5. The doctor, who was 83 years old, had served as president of the State Medical Society in 1912 and was granted the first Council Award of that organization.

The doctor was born on October 5, 1866, in Waynesburg, Pa. He obtained his medical degree from Starling Medical College, Columbus, Ohio, in 1889, and shortly thereafter he established his practice in Ashland. There he helped in the founding of Ashland General Hospital, now Trinity Hospital, and for many years was president of its board of trustees.

Doctor Dodd was prominent in many fields. For 15 years he was a member of the State Board of Medical Examiners, serving as its secretary for nine years. He was mayor of Ashland for two terms, from 1910 to 1912 and from 1933 to 1937. By public vote, Dodd gymnasium was named in his honor. The doctor was a president of the board of Northland College for forty years. During World War I he was a major in the Medical Reserve Corps, and during World War II he headed the Ashland County Council of Defense. Late summers of the doctor were spent in Alaska, where he was superintendent of a hospital in the salmon fishing industry. For many years he was a trustee of the Interstate Postgraduate Medical Association of North America, which office he held to the time of his death. In this capacity he was associated with such men as Drs. Will and Charles Mayo and Doctor Crile of Cleveland, who also served as trustees.

The author of "Autobiography of a Surgeon," published in 1928, Doctor Dodd was a charter member of the American College of Surgeons. He was a life member of the State Medical Society and a member of its Fifty Year Club. From 1903 to 1930 he had served as councilor of the Society. He also held membership in the Ashland–Bayfield–Iron County Medical Society and the American Medical Association.

Surivors include his wife, three daughters, and a son, Dr. John Dodd, Jr., of Santa Barbara, Calif.

Dr. L. A. Van der Linde, 66, retired Milwaukee physician, died on August 4 at a Hayward hospital. He had been vacationing at his summer home on Lac Court Oreilles.

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The doctor was born on May 1, 1884. He received his degree in medicine from Hahnemann Medical School, Chicago, in 1908 and established his first practice at Wild Rose. Later he practiced at Wautoma for six years before entering the Army Medical Corps during World War I. Following his discharge, with the rank of captain, he located in Milwaukee, where he served on the staff of St. Mary's Hospital for thirty years.

The doctor was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife and a daughter.

Dr. Francis E. Turgasen, practicing physician at Manitowoc for twenty-six years, died suddenly at his home in that city on August 14. He was 60 years old.

Doctor Turgasen was born in the town of Akan, near Richland Center, in 1889. He graduated from the University of Wisconsin and obtained his medical degree from Rush Medical College, Chicago, in 1916. Following internship at Cook County Hospital, Chicago, he entered the Army Medical Corps during World War I. In 1919 he joined the staff of the Marshfield Clinic in Marshfield, moving to Manitowoc in 1924.

Doctor Turgasen was a member of the Manitowoc County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife, a daughter, and a son.

Dr. Paul M. Currer, a Milwaukee physician and surgeon for almost forty years, died suddenly at his home on July 8. He was 62 years old.

Doctor Currer was born in Gerard, Kansas, on July 11, 1888. He received his medical degree from the University of Illinois College of Medicine in 1910 and practiced for a short time in Two Harbors, Minnesota, before locating in Milwaukee in 1911. Doctor Currer was on the staffs of the Deaconess and Milwaukee County General and Emergency hospitals.

A former president of the Medical Society of Milwaukee County, the doctor was also a member of the State Medical Society and the American Medical Association.

He is survived by his wife, three daughters, and two sons.

Dr. Robert C. Schodron, Milwaukee physician, died on July 10 after collapsing in his automobile. He was 50 years old.

The doctor was born in Hartford on November 17, 1899. He received his medical degree from Marquette University School of Medicine in 1928, interning at St. Mary's Hospital, Madison. Shortly afterward he entered practice in Milwaukee.

Doctor Schodron was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include three sisters and two brothers.

Dr. W. S. Waite, retired Watertown physician, died at a hospital in that city on July 12. He was 70 years old.

Born at Friendship on October 9, 1879, he taught school for a number of years before entering medical school. In 1911 he received his M.D. degree from the Medical Department of Loyola University, Chicago, and shortly afterward he established a practice at Kendall. He moved to Watertown in 1922 and retired from active practice about a year ago.

Doctor Waite was a member of the Jefferson County Medical Society, the State Medical Society, and the American Medical Association. He served on the staff of St. Mary's Hospital, Watertown.

He is survived by his wife, a son, and a grandson.

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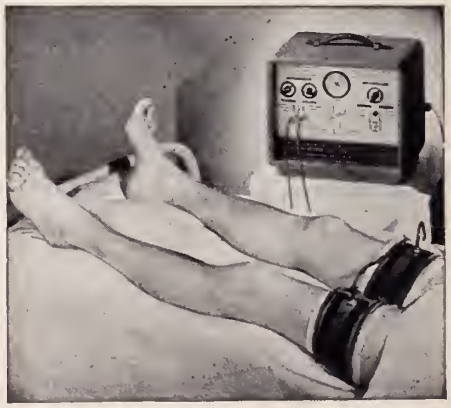

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The Temporal Bone and the Ear. By Theodore H. Bast, A.B., Ph.D., Professor of Anatomy, University of Wisconsin, Madison, Wisconsin; and Barry J. Anson, M.A., Ph.D., Professor of Anatomy, Northwestern University Medical School, Chicago, Illinois. Springfield, Illinois Charles C. Thomas, Publisher, 1949. Price $12.00.

This volume contains 448 pages of text and is well illustrated with 165 schematic sketches, microphotographs, photographs of models, and anatomic drawings. The authors present here an account of the development of the inner and middle ears, chiefly, and a discussion of histologic variations and pathologic processes encountered. The last chapter is devoted to an excellent survey of historical concepts regarding the ear, emphasizing the theories of hearing.

The material is presented in a well organized manner, utilizing the outline form. The first chapter is given to a brief review of the temporal bone and the ear proper. The following three chapters describe the development of the otic and periotic labyrinths and the otic capsule. The fifth and sixth chapters are devoted to histologic variations, pathologic processes, and bone dystrophies. Particular attention is paid to the sites of predilection for otosclerotic foci. Chapters 7 and 8 are devoted to the origin and development of the middle ear and related air spaces and the auditory ossicles. The final chapter presents historical concepts of the structure and function of the inner ear, including a survey of most of the many theories of hearing and vestibular function from 550 B.C. to the present date. These are rarely contained in any single volume.

Preponderant attention in the textual material and illustrations is given to features concerning which information has been sparse, erroneous, or misleading. The authors also offer the more descriptive and less misleading terminology as suggested by Streeter. In chapter 2 they bring forth newer concepts of the neural mechanism of the otic labyrinth based upon recent degeneration experiments in the cat, as performed at the University of Wisconsin.

Doctor Bast and Anson have drawn their material from an exhaustive study of microscopic sections of more than 550 series of fetal temporal bones employing the combined collection of Harvard, Yale, Northwestern, and Wisconsin universities. This work undoubtedly represents the most authentic and comprehensive study on the subject presented, and will serve as an invaluable reference to any student, teacher, or practitioner in the field of otology.—C.R.T.

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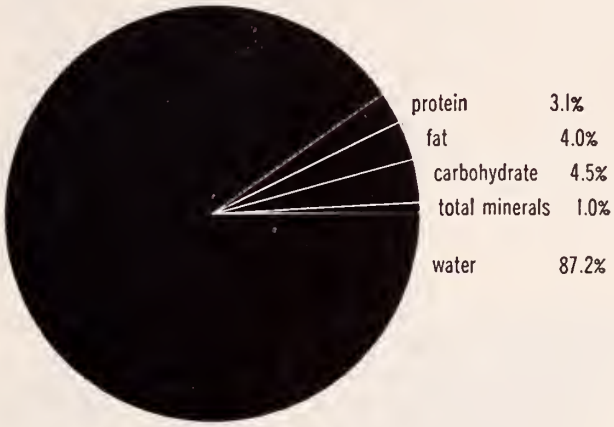

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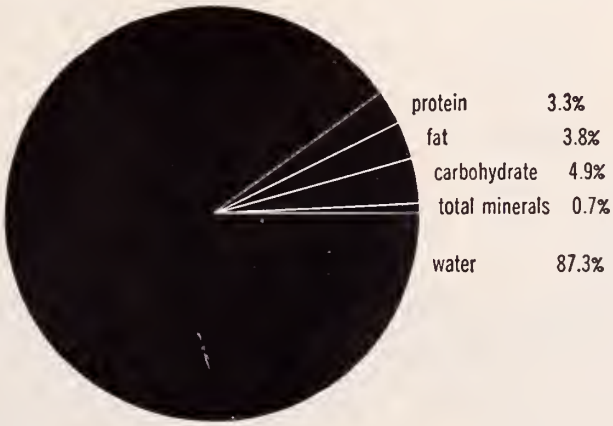

Roentgen Diagnosis of the Extremities and Spine. By Albert B. Ferguson, M. D. Volume 17 of Annals of Roentgenology. Second edition, revised and enlarged. New York, Paul B. Hoeber, Inc., 1949. Price $15.00.

Following an early reprinting and enlarging of the first edition, Ferguson's book now has been issued in a second edition, an indication that it has received a favorable response from those interested in this phase of roentgen diagnosis. Two chapters and 71 illustrations have been added to cover more adequately the anomalies of the spine and the malignant tumors of bone, bringing the total number of illustrations to 631.

In general, there has been little alteration of the original text, and the method of presentation remains the same. A considerable portion of the book is given over to a discussion and illustration of the finer changes that may occur in various diseases and injuries and how these features may be used to identify the lesions responsible for them.

The book is a compilation of the author's personal experiences, and no references to the literature are given. All illustrations are negative reproductions of the original roentgenograms. In the reviewer's opinion this detracts considerably from their value, particularly to the beginner or the casual observer of roentgenograms who may have difficulty in orienting the structures shown and recognizing the pathologic changes depicted. There is only a brief reference to herniation of the intervertebral disk and only a few illustrations of myelograms.

There will be disagreement with some of the author's opinions, but this should not detract from the value of the book, since most of the statements expressed are sound and many are original. The author's style is clear and concise and the printing is of excellent quality.

The book should continue to appeal to roentgenologists and orthopedists who desire a profusely illustrated text emphasizing the finer changes by means of which diseases can be identified with reasonable assurance. It can be read with profit by anyone interested in this aspect of medical practice. —L.W.P.

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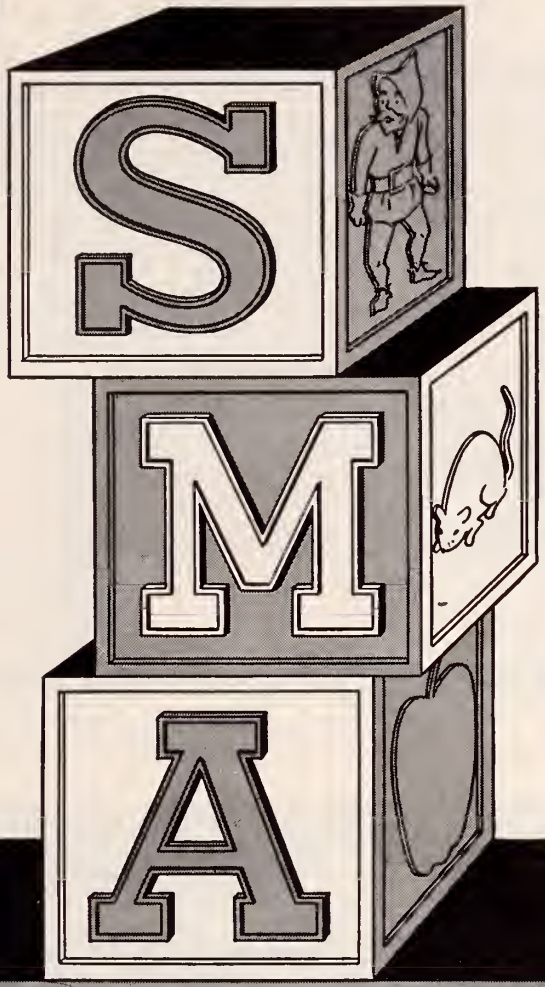

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(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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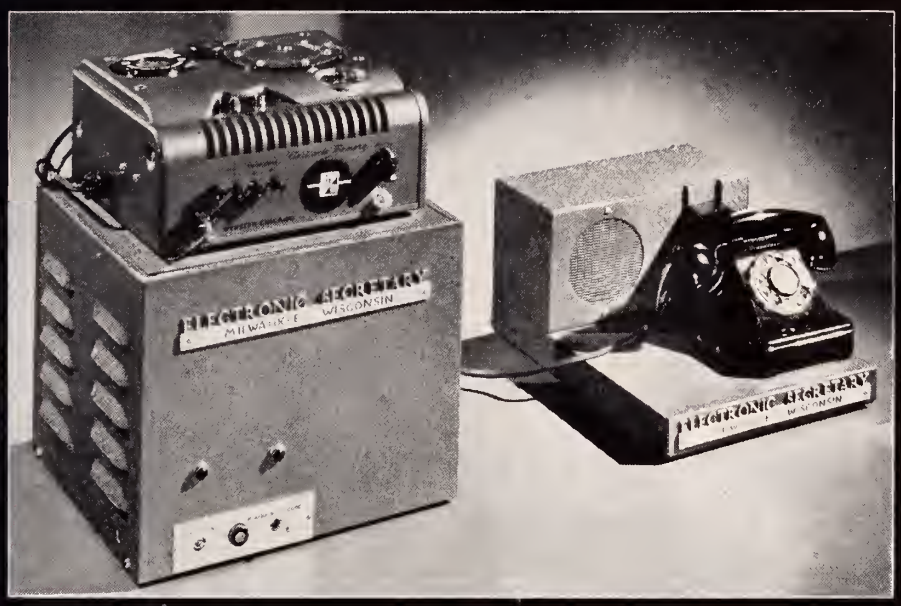

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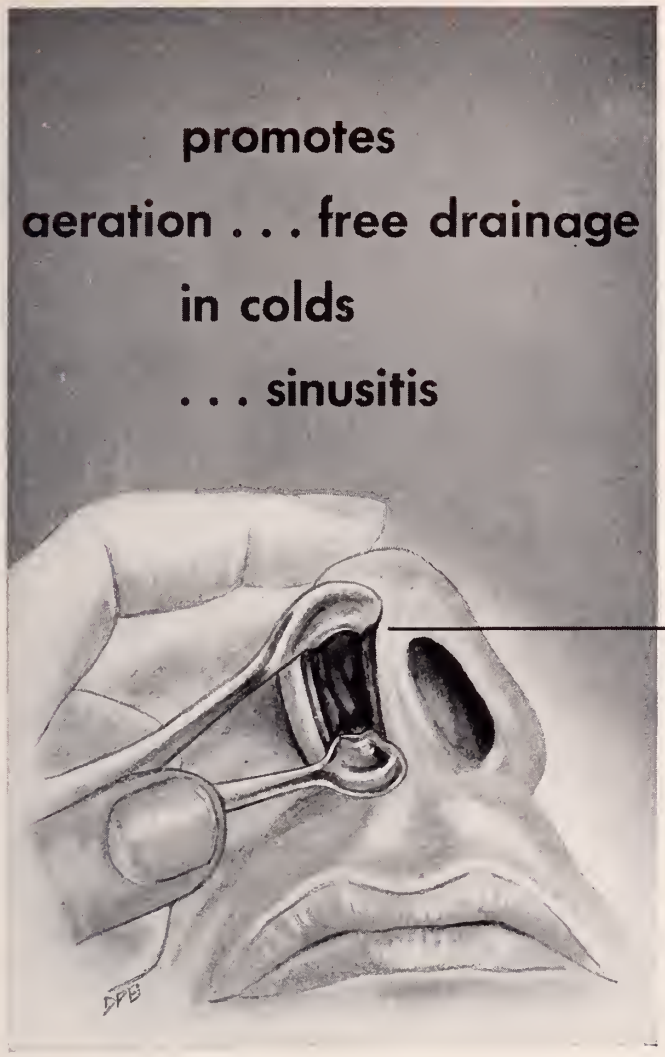

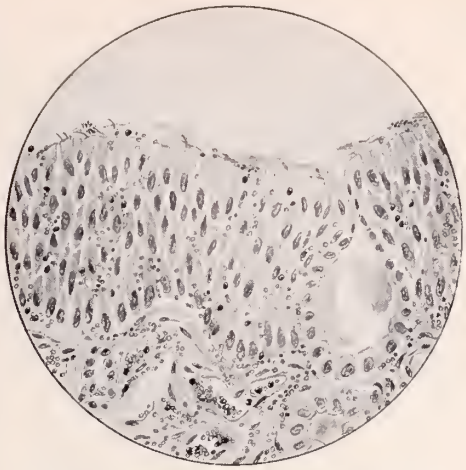

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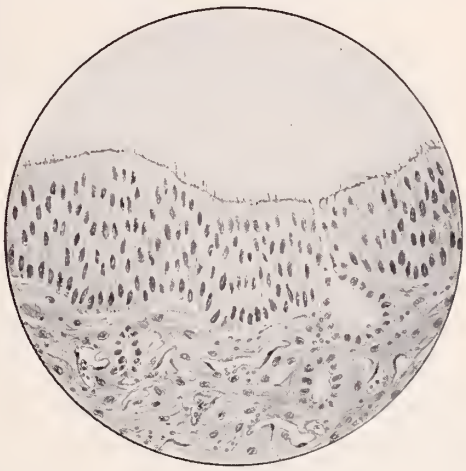

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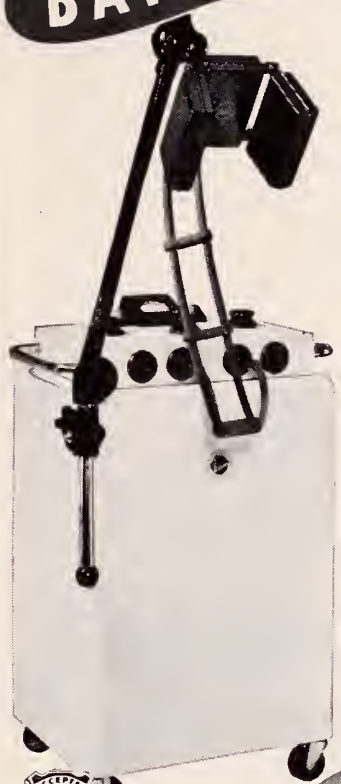

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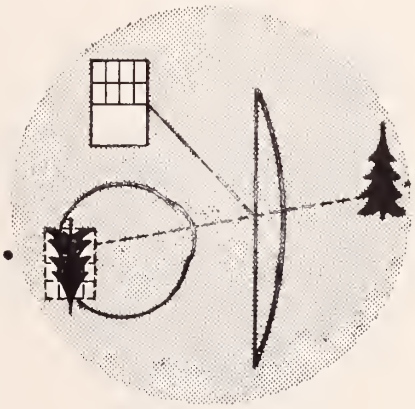

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Therapy: Terramycin, 2 Gm. daily for 5 days; orally in divided doses q. 6 h.

Result: Urine culture negative except for P. vulgaris by 2nd day of treatment. Response described as "good".

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1. Kmg, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J. A. M. A. 143:1 (May 6) 1950.

2. Herrell, W. E.; Heilman, F. E.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950

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A New Drug..for the treatment of ventricular arrhythmias

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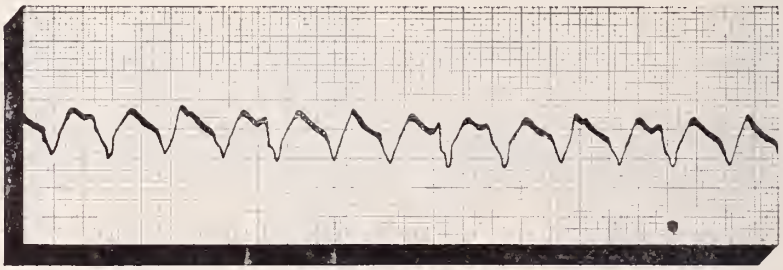
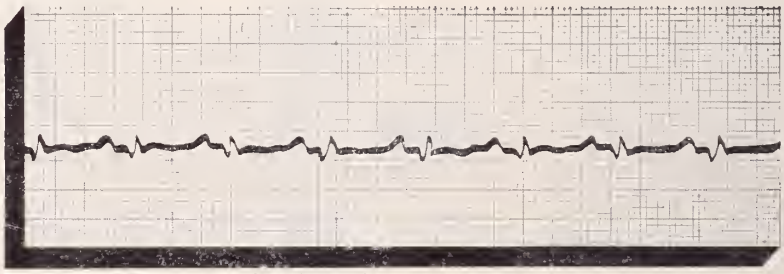


Lead II. Ventricular tachycardia persisting after six days of oral quinidine therapy (8 Gm. per day).

AFTER



Lead II. Normal sinus rhythm after oral Pronestyl therapy.

Effective in some patients with ventricular tachycardia who failed to respond to quinidine

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Squibb Procaine Amide Hydrochloride

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new product brief

PRONESTYL *Hydrochloride*

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for the treatment of ventricular arrhythmias

What is it?

Pronestyl Hydrochloride is Squibb procaine amide hydrochloride. Structurally, Pronestyl differs from procaine only by the presence of the amide grouping (.CO.NH.) in Pronestyl where procaine has the ester grouping (.CO.O.)

How does it act?

The action of Pronestyl is probably due to a direct depressant action on the ventricular muscle. In auricular arrhythmias, preliminary observations indicate that Pronestyl slows auricular rate but usually does not re-establish normal sinus rhythm. At present, Pronestyl is not recommended in the treatment of auricular arrhythmias.

When is it indicated?

In conscious patients, for the treatment of ventricular arrhythmias.

During anesthesia, to correct cardiac arrhythmias.

What are its advantages in ventricular arrhythmias?

As compared with quinidine: Unlike quinidine, no important toxic symptoms have been reported following the use of Pronestyl orally. In therapeutic dosage, Pronestyl orally does not produce the nausea, vomiting, and diarrhea often caused by quinidine. At high oral dosage, these symptoms may appear.

Whereas intravenous administration of quinidine is hazardous and unpredictable, Pronestyl may be given intravenously with relative safety.

Pronestyl has been found effective in some patients who failed to respond to quinidine.

As compared with procaine: For arrhythmias, procaine is used only in anesthetized patients because its dose in unanesthetized patients is too toxic for clinical use. Pronestyl can be used in conscious and anesthetized patients.

Intravenously, Pronestyl is much less toxic than procaine. In the recommended intravenous dosage, Pronestyl does not cause the central nervous system stimulation typical of procaine in conscious patients.

Procaine is unstable, being rapidly hydrolyzed in the plasma to para-aminobenzoic acid and diethylaminoethanol. Pronestyl is not affected by the plasma procaine esterase, consequently it is much longer acting than procaine.

Procaine is not used orally because of its instability in the organism; Pronestyl can be used orally and intravenously.

What are its side effects?

Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of the blood count, urine, liver function, blood pressure, and electrocardiogram. Intravenous administration to patients without ventricular tachycardia produced only a moderate and transient hypotensive effect in about one-third of the subjects. However, during intravenous administration to patients with ventricular tachycardia, a striking hypotensive effect was almost invariably present. This disappeared concurrently with the establishment of a normal rhythm. Further studies are in progress to see whether the drug may be given intravenously over a period of time longer than five minutes so as to revert the ventricular tachycardia without causing hypotension. That this may be possible is indicated by the fact that some episodes of ventricular tachycardia have been successfully treated by oral administration without significant change in blood pressure. Electrocardiographic changes: prolongation of QRS and QT intervals and occasional diminution in voltage of QRS and T waves have occurred.

What is the dosage?

IN CONSCIOUS PATIENTS

For the treatment of ventricular tachycardia:

ORALLY. 1 Gm. followed by 0.5-1.0 Gm. every four to six hours as indicated.

INTRAVENOUSLY: 200-1000 mg. (2 to 10 cc. Pronestyl Hydrochloride Solution). *Caution—administer no more than 200 mg. (2 cc.) per minute.*

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. If marked hypotension occurs, rate of injection should be slowed or stopped.

For the treatment of runs of ventricular extrasystoles:

ORALLY: 0.5 Gm. (2 capsules) every four to six hours as indicated.

IN ANESTHESIA

During anesthesia, to correct ventricular arrhythmias:

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1. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 5th ed., 1946, 704-705.
2. Beckman, H.: Treatment in General Practice Philadelphia, Saunders, 6th ed., 1948, 744.

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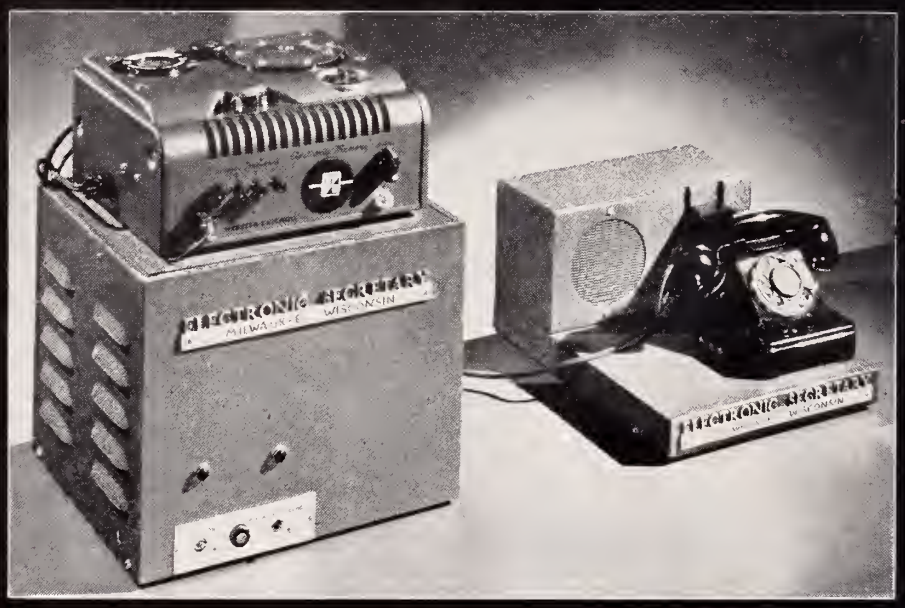

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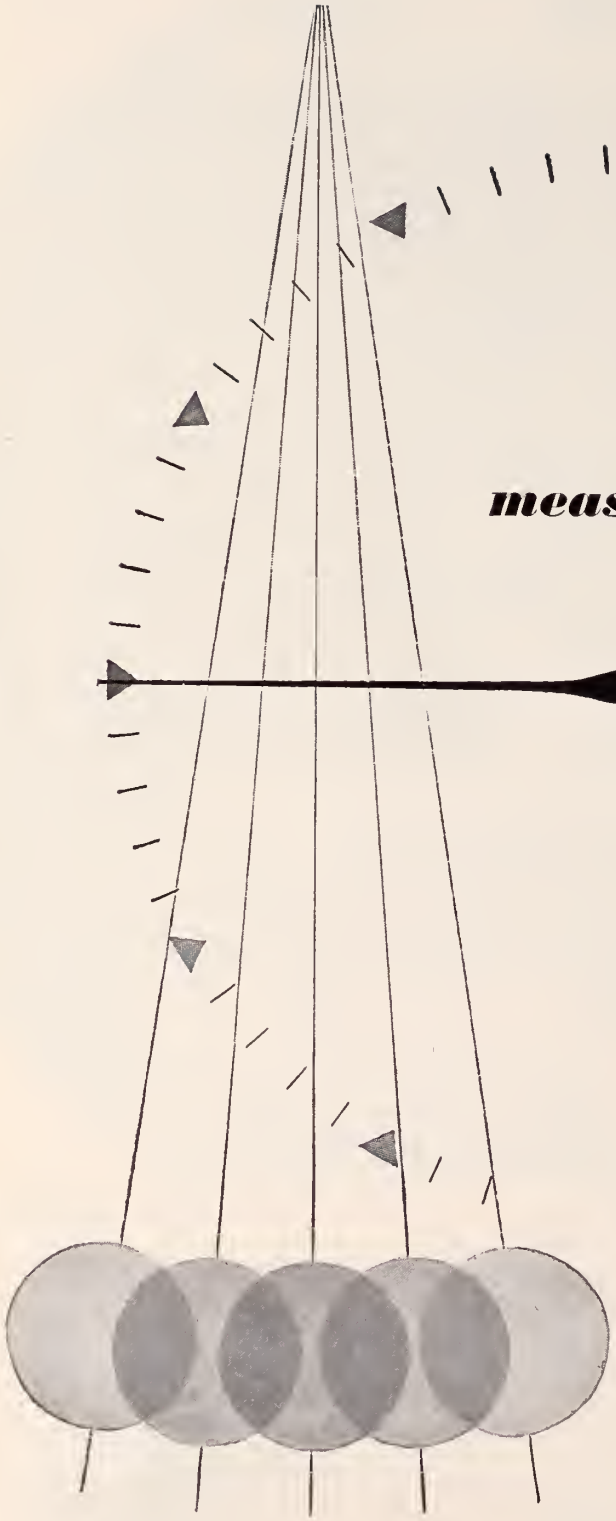

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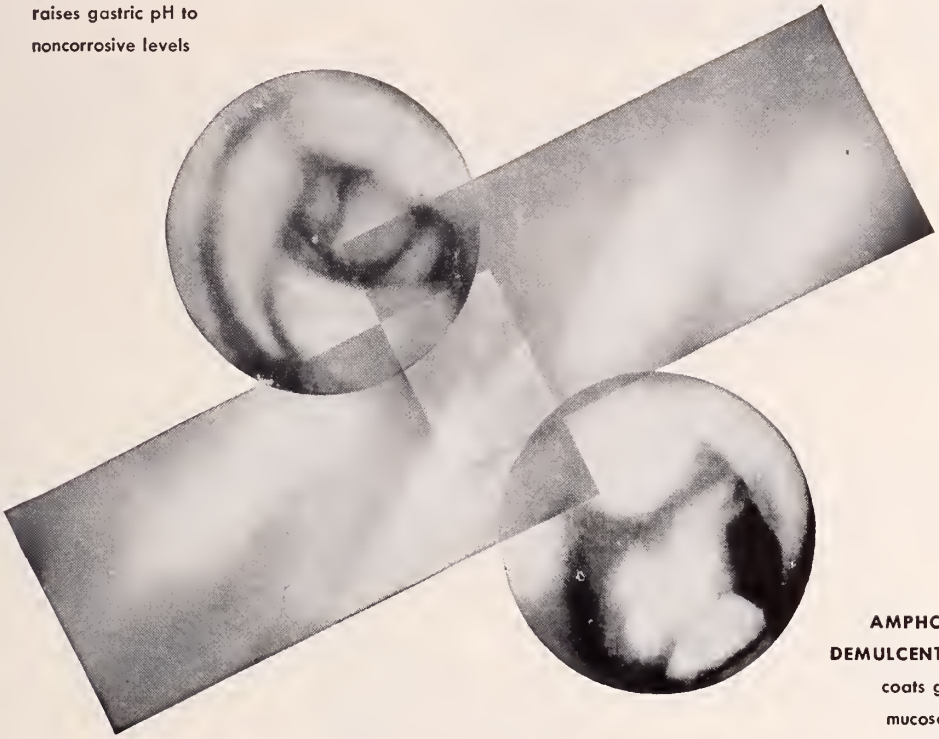

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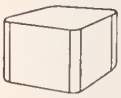

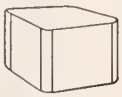

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« « « EDITORIALS » » »

An Attack on Multiple Sclerosis

A most significant forward step in the field of multiple sclerosis has been taken at the University of Wisconsin Medical School. The formation of a multiple sclerosis clinic to serve the physicians of Wisconsin is of utmost importance not only to the doctors, but to social agencies and the general public.

The incidence of multiple sclerosis in Wisconsin is among the highest in the nation. Its tendency to attack and disable individuals in the prime of life creates great social as well as medical problems.

For many years physicians of Wisconsin have been meeting the problem purely on an individual basis. The National Multiple Sclerosis Society, formed in 1946, has obtained a wealth of important information by means of specific coordinated research through five regional chapters. Until now, no chapter has been located in the strategic multiple sclerosis belt in Wisconsin.

Last month, at the suggestion of Dr. Hans H. Reese, a member of the medical advisory council of the National Multiple Sclerosis Society, with the aid and approval of Dean W. S. Middleton and the support of Dr. W. J. Bleckwenn, chairman of the department of neuropsychiatry, the Wisconsin Multiple Sclerosis Society was formally established at the medical school in Madison. Dr. Edward P. Roemer was named director.

Its aims are threefold:

1. To provide a diagnostic and consulting service for the physicians of Wisconsin.
2. To disseminate information and treatment schedules concerning multiple sclerosis and allied conditions to the physicians.
3. To conduct research in multiple sclerosis and allied demyelinating or degenerative conditions.

Tremendous benefit can accrue to the physicians depending upon the degree of their cooperation. The clinic will be open weekly on Wednesday and Friday from 2 to 5 p.m. in Bradley Memorial building. Patients will be admitted by appointment only—upon referral from their physician or from public agencies in accordance with state regulations. The profession is invited to attend these outpatient clinics.

The second aim of the clinic involves the establishment of a multiple sclerosis registry, by which all cases of multiple sclerosis will be voluntarily re-

ported by all Wisconsin physicians. This will provide a valuable fund of knowledge not now known about the disease in Wisconsin.

Graduate instruction with discussion sessions is contemplated, and an excellent follow-up system can be established with the cooperation of all physicians. The participation of physicians in the clinic program will enable them to take part in the research studies. It is not the intent of the clinic to regiment thoughts and effort in regard to multiple sclerosis, but rather to stimulate ideas and open new channels for investigation so that the widest possible experience can be gained.

A panel of sixteen consultants from many fields will assist in the clinic operations.

The magnitude and the immediacy of the multiple sclerosis problem in Wisconsin make it important that all Wisconsin physicians: (1) report suspected or diagnosed cases of multiple sclerosis to the Wisconsin Multiple Sclerosis clinic for inclusion in the multiple sclerosis registry; (2) refer "probable," "doubtful," and "unlikely" cases to the clinic for evaluation as ambulatory referred patients; (3) send "true," "certain," and "sure" cases of multiple sclerosis to the clinic for study and research investigations so that recommendations for treatment can be advised. These procedures will be carried out at home by the referring physicians; and (4) become affiliated members of the Wisconsin Multiple Sclerosis clinic. All inquiries should be addressed to Wisconsin General Hospital, Wisconsin Multiple Sclerosis Clinic, % Dr. Edward P. Roemer, 1300 University Avenue, Madison 6, Wisconsin.

The urgency of the problem and its importance to the public and social agencies dealing with the multiple sclerosis patient demand the active cooperation of all physicians.

Although patients will be admitted only by referral from their physicians, it is the patient's physician who will give and supervise the ultimate care of the patient. It is hoped that the clinic will function as a valuable guide in this program of treatment and rehabilitation. If this cooperative plan is consummated, a wealth of information will be collected and, of greatest importance, the multiple sclerosis patient will receive the most benefit.

Present Day Treatment of Syphilis

Elsewhere in this issue there appears a paper on present day treatment of syphilis prepared by Dr. G. A. Cooper for the Committee on Venereal Diseases. Since the advent of the antibiotics, the treatment of venereal diseases has changed radically. The number of patients with early syphilis has dropped to such an extent that venereal disease clinics in Wisconsin, outside Milwaukee, have been closed. Thus the responsibility for adequate treatment of early syphilis rests almost entirely with the general practitioner. For these reasons the Committee felt that an outline of diagnostic procedures and recommended methods of treatment would be helpful to the practicing physician.

Of the many antibiotics discovered so far, only penicillin occupies a definite place in the treatment of syphilis. Other antibiotics, such as Aureomycin and Terramycin give promise of being effective, but they are still in the experimental stage, and, therefore, cannot be recommended for general use.

Penicillin has revolutionized the treatment of syphilis in certain respects. It has allowed us to substitute a very harmless and convenient drug for the more dangerous arsenicals. With the use of penicillin, the treatment time for syphilis has been shortened tremendously. Instead of the 12 to 18 months required for the older methods, only a few weeks' treatment is needed with penicillin. The result of this has been that many more patients with early syphilis now receive adequate treatment. That means penicillin actually cures more syphilitic persons. Therefore, penicillin has become the drug of choice in the treatment of syphilis.

The recommendations endorsed by the Committee include accepted methods which have been tried throughout the country during the last few years. Although more than six years have passed since penicillin was first used in the treatment of syphilis, there is not yet general agreement as to what constitutes the best method for its use. As time goes on, changes may be necessary. Perhaps in the early enthusiasm the treatment time has been shortened too much. As late manifestations of syphilis may occur after 10 or 20 years, or after even longer intervals, we shall have to wait a long time for a final evaluation of different methods of treatment.

The present fluid state of opinions on treatment of syphilis has been given consideration in Doctor Cooper's paper. Alternative schedules are presented in several instances. There are still some who believe that in the early stages of the disease a combination of penicillin with an arsenical and bismuth is superior to treatment with penicillin alone.

Rigid schedules for the treatment of syphilis actually can be given only for the primary, secondary, and latent stage. In tertiary syphilis, cardiovascular lues, and neurosyphilis, treatment must be individualized, and any schedule can provide only a rough guide.

For your convenience, treatment schedules and diagnostic tables have been inserted so that you may take them out for easier reference.

This issue contains the article on syphilis; in subsequent numbers of the *Journal*, papers on gonorrhea, chancroid, lymphogranuloma venereum, and granuloma inguinale will be published.

Should the General Hospital Provide Psychiatric Services?

By CARL L. KLINE, M. D.
Milwaukee

C. L. KLINE

Doctor Kline, a diplomate of the American Board of Psychiatry and Neurology, is in private practice in Milwaukee and serves on the staff of St. Mary's Hill Sanitarium. He was graduated from Northwestern University Medical School in 1941, and, following internship, entered the United States Navy. Following his discharge, he completed residency training in psychiatry at St. Elizabeth's Hospital, Washington, D. C., and Duke Hospital, Durham, N. C.

IN 1942 Dr. Lawrence Kubie,[1] in an article in *Psychosomatic Medicine*, called attention to the fact that among the 4,309 general hospitals in the United States, only 112 had provisions for the care of even the mildest nervous or emotional disturbances. In Wisconsin today there are practically no provisions in general hospitals for the care of any kind of psychiatric disabilities. In Milwaukee, for example—the city having the largest number of psychiatrists—there is just one general hospital providing psychiatric care. One of the major hospitals in Milwaukee is planning to institute such care soon.

What is the Need?

Perhaps the question of need is basic to this whole discussion. Experienced physicians and specialists in various fields, including pediatrics, have estimated that from 35 to 75 per cent of their private practice consists of patients whose illness is primarily determined by emotional factors. Rees and Billings[2] reported that annually in the hospitals of Colorado alone from 3,000 to 9,000 patients are admitted with physical diagnoses which later turned out to be predominantly psychiatric. In an extensive study, Heldt[3] found that "from 12 per cent to 20 per cent of all patients admitted to any general hospital present conditions and problems that are primarily psychiatric." He adds that if one includes patients showing emotional problems of secondary importance, the percentage rises to 30 or higher.

Dunbar studied 1,500 cases of cardiovascular disease, diabetes, fractures, allergies, and gastrointestinal disorders in patients between the ages of 15 and 55 and found "important psychic components" in 80 per cent. My personal experience, working on the private and public medical and surgical wards of Duke Hospital for a year, while a Fellow in psychosomatic medicine, is in keeping with these observations.

In addition to the so-called psychosomatic illnesses, which constitute a group on the borderline between medicine and psychiatry, there is a large group of purely psychiatric illnesses which needs consideration. The frank psychoses, should, generally speaking, be treated in psychiatric hospitals. A few especially well situated, well planned, and well staffed general hospitals can, however, operate an acute diagnostic and treatment service even for these patients.

There are a large number of other psychiatric conditions for which patients need a relatively brief period of hospitalization and treatment which could well be handled in a properly organized general hospital. This group would include the depressions, particularly those of middle life, in which there are no marked disturbances of behavior or thought content, but in which hospitalization is very important. Cardiovascular disease is often present in these patients, requiring the cooperation of the general physician or internist. Most of these patients are understandably reluctant to enter a psychiatric institution, private or public. Often the result is that treatment is not obtained and a curable condition becomes chronic and often incurable. Suicide is a not uncommon end result.

There are also many patients presenting a problem of differential psychiatric diagnosis for whom a period of hospital observation would be invaluable in diagnosis and treatment. Many of these patients are, so to speak, on the verge of serious mental illness, but a period of prompt hospital care in a properly organized general hospital would be of tremendous therapeutic value in staving off disaster. In addition. there are many neuroses of various kinds in which a period of hospitalization is invaluable, enabling the psychiatrist to begin a process of psychotherapy which soon can be continued on an out-patient basis.

Family physicians, specialists in other fields, and psychiatrists are often confronted with the frustrating problem of how to obtain hospitalization for a patient in one of these psychiatric categories. Often there is just no answer to the problem under existing circumstances. Is the need great? Many doctors, social workers, ministers, and individual citizens, and all psychiatrists will answer emphatically in the affirmative. But trying to get such a patient into a general hospital is like trying to get a patient with scarlet fever admitted to the obstetric ward. Special provisions are, of course, made in every hospital for infectious and contagious diseases. Special provisions should now be made for psychiatric illness, illness which can often be more serious and incapacitating in its immediate effects and in its sequelae than can such illnesses as scarlet fever.

Some Economic Factors

General hospitals equipped and staffed to give psychiatric care will not only be serving their communities more effectively and more honestly, but apparently are apt to benefit economically. Lack of psychiatric awareness and lack of the availability of good psychiatric consultation in the "organic" conditions alone is a major source of therapeutic impotence. Unless these patients are handled with due regard for the neurotic aspects of their illnesses, whether this neurotic component is primary or secondary, response to therapy is often hindered and the doctor-patient relationship often suffers. It is estimated that adequate psychiatric cooperation with first admissions to hospitals would save the hospitals far more than the cost to provide such care. Billings, McNary, and Rees (psychiatrist, business manager, and superintendent) report[4] that the introduction of a psychiatric service in their hospital has actually decreased the hospital stay of such patients and "saved the institution money."

Neurotic complications of illness are apt to prolong the illness, cause recurrences, and interfere with therapeutic attempts. In addition, such complications, or illness in a neurotic character, often greatly increase the amount of laboratory and x-ray work ordered and reordered.

According to Kubie, in the few general hospitals where adequate private and semi-private provisions are made for the care of neurotic patients, these facilities contribute substantially to the support of other departments of the hospital. In Galveston, Texas, the John Sealy Hospital, a general hospital, has a general private pavilion of about 30 rooms. In addition it has a psychiatric wing of 60 beds. These psychiatric rooms and beds are always filled and help to pay some of the general expenses of running the hospital and to carry the chronic deficit of the private pavilion for general medical and surgical patients.[5]

These economic factors may not seem so important in this day of over-all shortage of hospital beds, but one must also think in terms of the future. Perhaps the greatest economic factor today would be in terms of length of hospital stay and the number of readmissions on medical and surgical services.

Why a Psychiatric Wing or Section?

Many patients with severe neuroses, depressions, early psychoses, and borderline psychoses can be promptly improved and reinstated into economic and social activities by a brief period of hospital care. Electric shock therapy, for example, will quickly rehabilitate many of the mid-life depressions. This treatment should be, as recommended by the Group for the Advancement of Psychiatry, given in a hospital.

Caring for these patients requires special training and experience on the part of the nurses and other hospital personnel. Certain precautions are essential to prevent suicide in depressed patients. In a psychiatric unit the personnel can be trained by the psychiatrist, if trained personnel are not available. Precautions can be established which could not be placed in effect on a general medical service. If such a section cannot be provided, cases for admission to the general services will have to be carefully selected by the psychiatrist. Even under these latter circumstances depressed patients can be handled, providing that 24 hour nursing service is available for the depressed patient. It should be remembered that delirious medical and surgical patients, many of whom are extremely difficult management problems, are treated in the general hospital.

A separate psychiatric section also simplifies the handling of the special charts and other records used for such patients; centralizes the various activity programs, such as occupational therapy, which may be part of the treatment program; and protects the patient from the curiosity of other patients in the hospital.

What Contributions Can the Psychiatrist Make to the Hospital as a Whole?

The presence of one or more well trained, dynamically oriented psychiatrists on the staff of a general hospital will in itself create a greater awareness of the emotional components of illness. From this alone, patients are bound to benefit. Just as there is competition and a certain amount of interprofessional jealousy on every staff — a certain amount of which has value—so will there be certain hostilities and insecurities created by the presence of a psychiatric service in the general hospital. Some doctors may feel that the psychiatrist thinks all disease is psychiatric and will attempt to force his opinions on to the staff and the patients. Some fears may arise that the psychiatrist will want to treat all the patients. Some physicians, especially the highly conscientious ones, may feel inadequate in their lack of knowledge of the emotional factors in disease and in their lack of knowledge of the methods of handling such elements.

Actually the psychiatrist should, in a consultative capacity, be available to staff members who wish to utilize his special knowledge. Obviously he can treat very few, perhaps none, of the patients seen in consultation. But he can often bring forth material which will be of great value to the attending physician in the total handling of the case. In addition, he can help interested staff members to become psychologically more sophisticated. And he can often help staff members to utilize psychotherapeutic principles in the management of their own cases.

Adequate care of patients demands not *either* the internist *or* the psychiatrist, but a continuous coordination of the efforts of both. Broadness of vision and bigness of mind are often needed to bring about such cooperation and coordination, but when it is present, all concerned will benefit.

In addition to the consultation service, the psychiatric members of the staff should play an active role

in research and in therapy. These latter two activities are more demanding of time and energy and may not be practicable in many general hospital organizations. If feasible, however, they will add a good deal to the total contribution which the psychiatrist can make to the total medical program of the hospital.

The Clinical Psychologist and the Social Worker

Somewhat as the medical man and the surgeon are dependent upon the laboratory and the x-ray, the psychiatrist is helped in his work by the clinical psychologist and by the psychiatric social worker. Well trained personnel in these fields often are not only helpful in obtaining information and data which are valuable in diagnosis and the planning of therapy, but also can play an important role as aides in therapy. As staff doctors become oriented in the emotional field, these personnel can often be utilized directly by them, as well as by the psychiatrist. Thus they come to serve, like the laboratory and x-ray, doctors in various branches of medicine.

For example, a gynecologist may have a patient with pelvic symptoms in whom he suspects that emotional factors play the leading role. He may sense that an operation for the ovarian cyst which is present may result in increase in symptoms rather than removal of symptoms. If he is oriented in psychiatry, he may request social studies and psychologic studies, which may, together with the information he has obtained, aid him in evaluating the case and often in helping the patient psychotherapeutically. Or the studies may combine to impress him with the fact that the problems are too deep-seated for him to attempt to work with. He will then be better able to prepare the patient for referral to a psychiatrist for treatment.

Other Areas of Service

Each general hospital will be limited by a number of circumstances in regard to the variety of psychiatric program it can offer. In addition to the foregoing areas which can be developed, mention should be made of the outpatient clinic. Psychiatric consultation should be available to every outpatient clinic, and, if at all possible, there should be a separate, but coordinated, psychiatric outpatient therapy clinic.

Psychiatric consultation at the outpatient level will definitely save many unnecessary hospital admissions. It may also save a number of patients unnecessary operations and unnecessary and ill-afforded expenditure of money. No surgeon wants to operate on a patient whose symptoms are the expression of an emotional conflict. Often this is much easier to detect postoperatively than preoperatively. The psychiatrist is not always helpful in these cases, but there will be enough occasions when he will be helpful to make the cooperative effort worth while.

General Summary

Without attempting to discuss specific plans for setting up a psychiatric service in the general hospital, an attempt has been made here to indicate the great need for such services and some of the possible applications of such services. Setting up such a service in a specific hospital involves many factors, such as size and location of the hospital, availability of space, availability of trained psychiatrists, and the attitude of the hospital staff. The opening of such a service should be done in consideration of all of these factors, and others. A conservative start upon which something of value can be built is far better than a premature and over-ambitious beginning which later must be discarded.

A carefully planned psychiatric program in all possible general hospitals in Wisconsin would do a great deal to alleviate the problem of mental hygiene in the state now and in the future. It would benefit the individual patients, the communities, the state, the hospitals themselves, and the members of the hospital staffs. The need is great, and the need is now.

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A ring of car keys was found in the Milwaukee Auditorium during the Annual Meeting of the State Medical Society. They may be obtained by writing to the *Journal*, Box 1109, Madison, Wisconsin.

The Subcutaneous Administration of Mercuhydrin (Meralluride Sodium Solution)*

By OVID O. MEYER, M. D.** and DORIS M. KURTH**
Madison

O. O. MEYER

Doctor Meyer, professor of medicine and chairman of the department of medicine at the University of Wisconsin Medical School, received his degree in medicine from the Columbia University College of Physicians and Surgeons in 1926. Recently he completed a tour of duty in Europe as an overseas medical consultant of the Army.

THAT the mercurial diuretics are the most powerful and consistently effective of all diuretic drugs is taken for granted. It has long been recognized, however, that they have toxicity, and there have been attempts for the past 25 years to develop increasingly effective mercurials of lower toxicity. An important step in that direction was made when it was found that combinations of mercury and a xanthine, the former chemical acting to decrease tubular re-absorption, the latter to possibly increase glomerular filtration, were more potent and much less toxic. Concurrently, routes of administration other than the intravenous, most commonly employed until about 1940, or the intramuscular route, popular since the introduction of a succinyl urea organic compound of mercury with theophyllin, Mercuhydrin (meralluride sodium solution N.N.R. 1949), a drug of low toxicity, have been tried. The assumption is made that the dissociation of mercury from this compound is so slow that the liberation produces a compound of mercury of lessened toxicity. Thus, rectal suppositories containing mercury and a xanthine have been employed, but largely rejected because of variability of effectiveness and because of rectal irritation. Most recently a new and potent mercurial diuretic has been made by combining an organic mercurial with a sulfhydryl group to produce N– (gamma hydroxymercuri-beta-methoxypropyl, camphoramic acid) (mercaptomerin)[1] which is marketed as "Thiomerin." This mercurial has been found to be an effective diuretic when given subcutaneously, although it may be given intravenously or intramuscularly. Hermann and associates[2] reported upon their study of the effect of Thiomerin administered subcutaneously to 100 patients with cardiac disease. They observed few reactions. In 3 patients, however, there was moderately severe and persistent pain for several days after the injection. In 2 of these with thick adipose tissue local infiltration resulted. The authors, in their conclusion, stated that Thiomerin is the only organic mercurial diuretic that is tolerated in the subcutaneous tissues. They warn against injecting it into edematous skin or adipose tissue.

Batterman, Unterman, and DeGraff[3] found mercaptomerin (Thiomerin) to be an effective and safe diuretic which is well tolerated by over 90 per cent of patients when administered subcutaneously, producing a degree of diuresis similar to that of intravenously injected mercurophylline.

In the summer of 1948, prior to Thiomerin being made available to us and before these reports of Hermann and associates[2] and Batterman and his colleagues,[3] recognizing the possible advantages of a diuretic which might be given subcutaneously, we began testing the feasibility of administering Mercuhydrin subcutaneously. Each cubic centimeter of this diuretic contains the equivalent of 39 mg. of mercury and 48 mg. of theophylline U.S.P. This is a report of our observations.

Methods

Patients on the wards of the State of Wisconsin General Hospital requiring diuretics, chiefly those with cardiac decompensation but some with ascites or edema due to portal obstruction, metastatic carcinoma, or hypoproteinemia, were given Mercuhydrin subcutaneously in doses ranging from 0.5 to 2 cc. Practically all injections were made in the arm, although rarely the injection was made in the thigh. No precautions other than those routine for any other hypodermic injection were taken. The intake and output were recorded in all instances. Where feasible, the patient's weight was determined daily. The morning after each injection, inquiry was made as to presence or absence of local pain and the site of injection was examined for signs of irritation.

A total of 273 injections of Mercuhydrin have been given to 68 adult patients. The number of injections per patient ranged from 1 to 29 and the total dosage from 0.5 to 29 cc. Forty-two of the 68 patients received doses totaling 3 cc. or more over a period of 3 to 29 days. Injections were usually, but not always, made daily or every other day. One patient received 20 cc. in 10 doses of 2 cc. daily. No attempt was made to withhold other medication such

** From the Department of Medicine, University of Wisconsin Medical School.

* This study was aided in large part by a grant from the Lakeside Laboratories, Milwaukee, Wisconsin.

as ammonium chloride, digitalis, anticoagulants, etc. However, in most instances of cardiac decompensation, several days for stabilization with bed rest, digitalis, and other therapy preceded the administration of the mercurial in order to better evaluate its specific diuretic effect.

Results

In none of the 68 patients was there an undesirable systemic reaction. In 11 of the 68 there were local reactions at the site of the injection. In 9 of these 11, the reaction was that of a mild to a moderately severe pain lasting 3 or 4 minutes up to 30 minutes. In most of these there was also slight local induration. In 1 of the 11 patients there was an area of ecchymosis 3 cm. in diameter at the site of injection. In most instances the reaction was the result of an injection of 2 cc. of the Mercuhydrin, and in none of these 10 was there a reaction great enough to require cessation of therapy. Other subsequent injections were completely free from local reactions. In the eleventh patient, however, who had hypertensive and arteriosclerotic heart disease, edema, and ascites, local reactions occurred. This patient received an initial injection of 0.5 cc. of Mercuhydrin and later received two additional doses of 1 cc. subcutaneously. There developed areas of induration approximately 3 cm. in diameter after each injection, with associated pain and slight redness. Nodules persisted for two weeks after the injections were stopped. Excellent diuresis followed each injection. No ulceration developed, although no specific therapy such as application of local heat was employed. Subsequent administration of Mercuhydrin intramuscularly was not attended by any reaction. This was the only patient in the group whose local reaction was sufficiently severe to necessitate stopping subcutaneous administration of the mercurial.

Similar diuretic effects were obtained by either subcutaneous or intramuscular injections. This conclusion was arrived at from comparing similar patients treated in the past with those receiving the present therapy and also by comparing diuretic effects of alternating subcutaneous and intramuscular injections in the same patient. That the subcutaneous administration of Mercuhydrin was effective as a diuretic was convincingly demonstrated many times. Failure of satisfactory diuresis occurred in those cases in which it might have been anticipated with any diuretic, however administered. That good diuresis is obtainable with the subcutaneous administration of Mercuhydrin is demonstrated in chart 1.

In 1 patient we repeatedly observed delays of five to eight hours before the beginning of diuresis following the hypodermic administration of Mercuhydrin, and there was an identical delay with intramuscular administration of the drug in this same individual. In general, the delay in diuresis and the duration have been similar with either the intramuscular or the subcutaneous administration of Mercuhydrin.

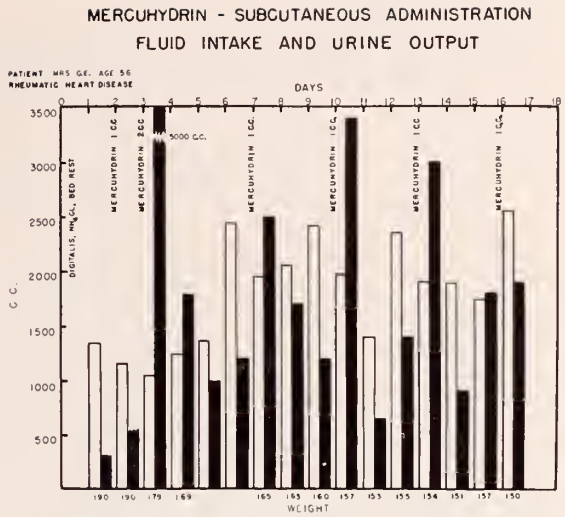

Chart 1.—Demonstration of the diuretic effect of Mercuhydrin when administered subcutaneously. White columns indicate intake; black, output.

Discussion

Although the number of patients and the number of injections of Mercuhydrin are not very extensive, our observations to date indicate that this diuretic can be administered to patients with reasonable safety and that essentially similar diuresis may be anticipated from subcutaneous and intramuscular injections. The local reactions, save for those of 1 patient, have been but mild and of short duration, and in this instance the reaction was not serious. The diuretic effects were not modified in any discernible manner by the presence or absence of local reactions.

Sussman and Stein [4] have advocated, based upon their experience in 1,000 trials, the use of subcutaneous injections of Mercuhydrin. They usually made injections into the thigh or buttock. We, however, gave all but a few subcutaneous injections into the arm, and it is probable that this may be the preferred site, as there is less likely to be edema here than in the thigh or back. It has been stated that Thiomerin should not be given into edematous tissue, and this warning might well hold for Mercuhydrin.

The advantages of subcutaneous injections over intramuscular or intravenous injections on occasion are rather obvious. In hospital practice, it is simpler and safer to have nurses give hypodermic injections than intramuscular injections. In the home it is possible to teach lay people to give subcutaneous injections of mercury as they are taught to give insulin. This is particularly advantageous when the patient can be visited by his physician at infrequent intervals. It is obvious that the need for continued medical supervision and periodic surveys for the patient cannot be eliminated.

Conclusion

1. The subcutaneous administration of meralluride sodium solution N.N.R. (Mercuhydrin) in doses up

to 2 cc. is a reasonably safe and effective procedure for promoting diuresis.

2. The diuresis thus produced is similar in degree to that produced by intramuscular injections of the same mercurial.

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AMERICAN COLLEGE OF PHYSICIANS TO HOLD MIDWEST REGIONAL MEETING

The midwest regional meeting of the American College of Physicians will be held at the Memorial Union Theater on the campus of the University of Wisconsin in Madison, November 18. Registration will begin at 8:00 a.m. and the scientific meetings will be followed by a social hour and dinner to be held at the Loraine Hotel in Madison, beginning at 5:30 p.m. The day will be filled by the presentation of scientific papers. In addition, a scientific exhibit will be provided in the foyer of the Memorial Union Theater. Details of the program follow. It must be emphasized that this meeting is open to all physicians whether or not they are members of the American College of Physicians. All physicians and their wives are cordially invited to be present and to participate.

Reservations for luncheon and dinner should be made immediately through Dr. H. M. Coon, 1300 University Avenue, Madison 6, Wisconsin.

SCIENTIFIC PROGRAM

A. M.

8:30 The Office Treatment of Diabetes.
M. M. Baumgartner, Janesville.

8:45 Tuberculous Pericarditis with Effusion: Diagnosis and Management.
*Howard Wakefield, Associate in Medicine, Northwestern University Medical School, Chicago; and Willis G. Diffenbaugh, Clinical Instructor in Surgery, University of Illinois.

9:00 The Clinical Syndrome of Myelofibrosis.
*John S. Hirschboeck, Dean, Marquette University School of Medicine, Milwaukee; and Anthony V. Pisciotta, Milwaukee.

9:15 The Oral Treatment of Pernicious Anemia.
*Stanley Miller, M.D., Instructor in Medicine; and Frank H. Bethell, Professor of Medicine, University of Michigan School of Medicine, Ann Arbor.

9:30 Clot Retraction, A Basic Factor in Thrombosis.
Armand J. Quick, Professor of Biochemistry, Marquette University School of Medicine, Milwaukee.

9:45 Clinical Significance of Vascular Spiders and Palmar Erythema.
William B. Bean, Professor of Medicine, University of Iowa School of Medicine, Iowa City.

10:00 Biochemical Studies on Vitamin B_{12}.
*C. A. Elvehjem, Professor of Biochemistry; and J. M. Williams, Jr., Assistant Professor of Biochemistry, University of Wisconsin.

10:30 INTERMISSION.

10:45 True Migraine is Due to Food Allergy—With Case Reports.
Leon Unger, Associate Professor, Northwestern University Medical School, Chicago.

11:00 Chronic Berylliosis.
O. A. Sander, Associate in Medicine, Marquette University School of Medicine, Milwaukee.

11:15 Clinical Usage of the Antihistaminic Drugs.
Kenneth P. Mathews, Instructor in Internal Medicine, University of Michigan Medical School, Ann Arbor.

11:30 Treatment of Infection Following Exposure to Ionizing Radiation.
*C. Philip Miller, F.A.C.P., Professor of Medicine; and Carolyn W. Hammond, Research Associate, Department of Medicine, University of Chicago.

11:45 Present Significance of Newcastle Disease and Vesicular Stomatitis as Animal–Human Public Health Problems.
*C. A. Brandly, Professor of Veterinary Science and Agricultural Bacteriology; and R. P. Hanson, Assistant Professor of Veterinary Science, University of Wisconsin.

12:15 Nature, Prophylaxis, and Therapy of Radiation Sickness.
Austin M. Brues, M.D., Senior Biologist and Director, Division of Biological and Medical Research, Argonne National Laboratory, Chicago.

LUNCHEON
Tripp Commons, Memorial Union

P. M.

2:00 Re-evaluation of the Fundamental Dynamics of Cardiac Failure in Terms of Response to Stress, Illustrated by Human Physiologic Studies.
*J. A. Campbell, Assistant Professor of Medicine (Rush); and Louis A. Selverstone, Instructor in Medicine (Rush), University of Illinois, Chicago.

2:15 Treatment of Congestive Heart Failure with 50 Mgm. Sodium Diet—Metabolic and Clinical Study.
*L. T. Iseri, Instructor and Research Associate in Medicine; A. J. Boyle, Professor of Chemistry; and G. B. Myers, Professor of Medicine, Wayne University, Detroit.

2:30 Periarteritis Nodosa: A Clinical and Physiopathological Study.
James A. Means, Milwaukee.

2:45 Differential Effects of ACTH and Cortisone on Capillary Permeability; Relation to Therapy of Exudative Skin and Collagen Disease.
R. Gordon Brown, Clinical Associate in Medicine; *Edwin N. Irons, Clinical Associate in Medicine; and S. Howard Armstrong, Jr., Professor of Medicine, University of Illinois, Chicago.

3:00 A Study of the Movements and Sounds of the Heart Valves (a motion picture and sound recording).
Harry L. Smith; N. E. Essex; and E. J. Baldes, Mayo Clinic, Rochester, Minn.
Discussion: Chester M. Kurtz, Associate Professor of Medicine, Univ. of Wisconsin.

3:30 INTERMISSION.

3:45 Alkap, the Forgotten.
LeRoy H. Sloan, Professor of Medicine, University of Illinois, Chicago.

4:00 Some Experiences with the Artificial Kidney in Acute Anurias.
D. G. Santer; J. K. Ollinger; and *D. M. Willson, Milwaukee.

4:15 Observations on the Effects of ACTH in Chronic Ulcerative Colitis.
*Joseph B. Kirsner, Associate Professor of Medicine; and Walter L. Palmer, Professor of Medicine, University of Chicago.

4:30 Metabolic Effects of ACTH Upon Pre-existing Diabetes Mellitus.
*Stefan S. Fajans, Instructor in Internal Medicine; and J. W. Conn, Professor of Medicine, Univ. of Michigan, Ann Arbor.

4:45 Enzyme Studies Directed Toward Cancer Chemotherapy.
Van R. Potter, Professor of Oncology, University of Wisconsin.

* Speaker.

The Massachusetts Vision Test—Two Years in Fond du Lac

By F. J. CERNY, M. D., and MRS. JANE SCHEER*
Fond du Lac

F. J. CERNY

A diplomate of the American Board of Ophthalmology, Doctor Cerny began practice in his specialty in Fond du Lac in 1947, following discharge from the Army Medical Corps. He received his medical degree from Loyola University School of Medicine and completed a residency at Presbyterian Hospital, Chicago, in 1943. The doctor is a member of the American Academy of Ophthalmology and Otolaryngology and the Chicago Ophthalmological Society.

THOSE of us who were fortunate enough to have vision testing in our school days probably remember a well worn cardboard chart that was hung at the end of a not too bright corridor or between two windows, with sunlight streaming in our eyes, and, between snickers and side-glances at our schoolmates, we tried to read the letters above the red line. If we managed this, our eyes were considered good; if we failed, a notice was sent home and there left to its fate.

It was realized, as both health education and ophthalmic science progressed, that this type of examination was truly inadequate. It did not tell us how hard the eyes had to work to see the letters, nor did it tell whether the eyes were acting as a coordinated team. In 1938 and 1939 a group of physicians, hygienists, and psychologists in Boston began an extensive and intensive search for a battery of tests which would detect almost every significant visual defect. After much testing, re-checking, elimination, and condensation, the Massachusetts vision test was evolved.[1]

The Test

In reality this "test" is a battery of tests, each for a different ocular function, and divisible into three steps. As now manufactured, the test is printed on a heavy cloth white screen, which rolls up, much like a movie-projecting screen, ino a long, narrow carrying case. The screen is illuminated from below by two standardized electric light bulbs, giving uniform and calculated illumination. The legs also fold up into the case, and the unit can be easily carried from school to school.

The child and tester sit 20 feet from the screen, and the child is first asked to read a line of illiterate "E" letters pointed in various directions, and conforming to 20/20 Snellen notation. (The other eye is covered by the examiner.) If he reads this correctly, the other eye is covered and another line is read (to prevent memorizing) by the second eye. If the 20/20 line cannot be read, the child is asked to read a similar 20/30 line, which is just below. If he fails this in either eye, the test automatically stops and a notation is made. This is part I.

If the child is successful, a pair of plastic glasses is slipped over the eyes, containing a pair of plus 1.50 spherical lenses. Again the child is asked to read the 20/20 lines. If he *can* read through these spheres, which produce blurring in the normal eye, he *fails* the test, since a significant amount of hyperopia (far sightedness) is assumed to exist. This is part II.

Part III is completed by placing another pair of frames over the patient's eyes, one side of which contains a Maddox rod. On the screen is a painted house, and in its center window a round electric light. The Maddox rod causes this light to appear as a horizontal streak before the one eye, and if the two eyes are not in normal balance, the streak will seem to fall outside the window, indicating a hyperphoria. The second frame, also with Maddox rod, is now placed before the eyes, and this time the streak appears vertical. If there is a lateral imbalance of the eyes (such as could occur in impending cross-eyes) the streak will seem to fall outside the house. Finally the patient looks at a small airplane with a similar spot of light, at a distance of 14 inches from the eyes, and the muscle balance is noted for near work.

The entire procedure requires only four or five minutes for children in the upper grades, and one or two minutes more for younger pupils.

Organization of Program

Since January 1948, the Fond du Lac Public Schools have been using the Massachusetts vision test. Interest in this test originated in the school health council, a group of individuals representing the health department, public, and parochial schools; PTA groups; and the county medical and county dental societies.

A demonstration of the test was given at a school health council meeting by a consulting ophthalmologist; and, after further investigation by the council, a recommendation was sent to the board of education to purchase two sets of the test.

Before the equipment was ordered and the test begun, ground work was laid in the community and in the schools. The purpose of the test was carefully explained to the students. In elementary schools, health units and projects concerning lighting and care of the eyes were stressed. The consultant ophthalmologist introduced the test to his county medical society and rallied the support of both ophthalmologists and optometrists. The test was also demonstrated to teachers and to parents. Articles in

* Health educator, Fond du Lac Public Schools.

the local newspaper and in the high school papers helped reach other individuals.

Since it is recommended that lay persons and not nurses do the screening, a core of selected lay persons was trained by the ophthalmologist in the use of the test. In the high schools, two persons in the physical education department were responsible for testing during gym classes. In the elementary schools wherever possible, the principal was trained. The health educator not only trained further personnel, but also did much of the actual testing. The number trained was kept to a minimum to assure as uniform results as possible.

The results of the screening test were the school nurses, who did the excellent, and most necessary, follow-up work, through home calls and letters to to parents.

Thus was demonstrated in full action a democratic community coordinating its efforts toward one goal —the improvement of the visual health of its youth.

Results

To determine the results of our efforts, it might be well to state the questions we asked ourselves, and then our answers, as culled from the records of our first two years.

How many tests were made?

Out of a public school population of 3,972 there were administered 2,013 tests: 911 the first year, and 1,102 the second.

How many children failed these tests?

There were 463 (22.9 per cent) who failed. The number failing the first year was 8 per cent higher, probably because of better testing procedure the second year and because the requirement in part II of the test was subsequently relaxed. Carefully confirmed statistics in Massachusetts revealed 39 to 40 per cent failures in 3,430 examinations, and a similar study in Ohio[2] showed 35 per cent failures in 300 examinations.

How many of those who failed actually consulted an eye doctor?

A percentage of 64.1 consulted an eye doctor. This in spite of good follow-up. We leave the moral to you.

How many of those consulting an eye doctor needed help—in the form of treatment, prescription, or change of glasses?

Of those consulting a doctor, 143 (48.9 per cent) needed help. As explained to the parents in the note which was sent home with them the defect may not be capable of correction; it may already be under proper treatment; or it may not in the doctor's opinion be severe enough to prescribe glasses or treatment. Then we must account for the wide range of methods of examination and treatment and equally wide range of standards among both ophthalmologists and optometrists. (In some cases the testing in the office may not go as far as did the vision test itself.) We must also take into account the physical condition of the child at the time of examination and the few natural errors of examination which may creep in, both on the part of the lay tester and the eye specialist. The value of the foregoing figures, then, is not in their notation of the accuracy of the test, but of the medicosocial interest to any community contemplating using the test.

How many students passed the first section of the test (which is equivalent to the old standard Snellen test given under good conditions) but failed other parts of the test?

There were 162 (8.04 per cent of all tested) who passed the first section; 4.91 per cent failed part II; and 3.13 per cent failed part III. In the original Massachusetts statistics, 7 per cent of failures occured in part II and 4 per cent in part III. The remaining 32 per cent of failures was in part I.

These figures give us the actual concrete value of the Massachusetts vision test as compared with a well administered Snellen test alone. We think that this difference is well worth while. There is no yardstick made to measure the value of eyesight. In view of our consistently lower percentage of failures, can it be said that Wisconsin grows healthier eyes?

Summary and Conclusions

The results of the first two years' experience with the Massachusetts vision test in Fond du Lac are reviewed, with comments concerning its use, and its concrete value to the community—which we believe to be great.

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RADIOLOGICAL SOCIETY OF NORTH AMERICA TO MEET IN CHICAGO

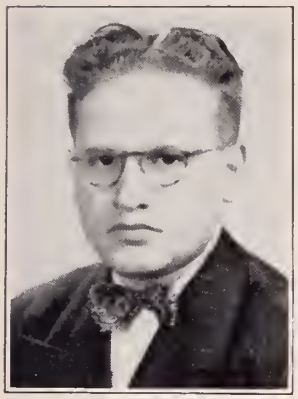
The Radiological Society of North America will hold its thirty-sixth annual meeting in Chicago, December 10 through 15.

Headquarters for the meeting will be the Palmer House in which all scientific and technical sessions will be held. Scientific exhibits are also to be displayed in the hotel. More than 60 papers as well as refresher courses feature the convention program.

Dr. Wendel G. Scott of St. Louis, Missouri, will present the annual Carmen Lecture. All members of the medical profession are invited to attend.

The Clinical Differentiation of Acute Appendicitis and Regional Enteritis

By MARVIN WAGNER, M. D.
Milwaukee



MARVIN WAGNER

Doctor Wagner, a graduate of Marquette University School of Medicine, maintains a private practice in general surgery in Milwaukee. Following internship at Mount Sinai Hospital in Milwaukee, he served with the Army Medical Corps, then returned to Mount Sinai Hospital for a three and one-half year residency in surgery.

A MOST perplexing problem which confronts the profession is the differential diagnosis of acute appendicitis. Sloan,[1] in his monograph, discussed 40 possibilities which must be considered. It is not our purpose to exhaust the entire diagnostic problem, but instead we will consider one phase, and that is the differential diagnosis between acute regional enteritis and acute appendicitis. In addition, a few comments about their management are included.

Our approach was to analyze critically the case histories of 1,062 patients who entered Mount Sinai Hospital between January 1940 and June 1949, whose preoperative diagnosis was acute appendicitis. Among these 1,062 patients, 12 were found at operation to have acute regional enteritis. In view of this, one may say that the percentage, less than 0.01 per cent is insignificant. However, when one notes[2] "that 50 to 60% of all patients with regional enteritis have had a previous appendectomy," there is certainly significance and importance in an attempt to clarify some of the distinguishing features of acute appendicitis and acute regional enteritis.

The average age of patients with acute appendicitis was 24 years, and that of acute regional enteritis, 26 years (table 1). Sloan[1] states that while 50 per cent of the patients with appendicitis are under 20 years of age, no person, regardless of age, is exempt from attacks of acute appendicitis. According to Bockus,[3] 75 per cent of the patients with acute regional enteritis are between the ages of 20 and 40 years, the average age being 29 years.

Crohn[2] states that males and females are affected with regional enteritis in a ratio of 3:2. However, in the various series of Clark, Bockus, and Marshall,[3] the sex incidence was about the same, as was true of our series (table 1).

The pain pattern is interesting and significant. Thirty-five per cent of the appendicitis patients presented themselves with a constant dull pain about the umbilicus or epigastric region. This pattern[4] fits in with the physiologic explanation, that the afferent fibers of the sympathetic nervous system are irritated, and the pain sense is reflected through the autonomic pathways (table 1). Forty-five per cent of the appendicitis patients first had pain about the umbilicus and epigastrium which later localized as a constant ache in the right lower abdominal quadrant. At this stage, Morley[4] explains that the intraluminal distention of the appendix increases markedly, the serosa is usually inflamed, the mesoappendix may be swollen, and the surrounding peritoneum is irritated by the inflamed appendix. The localization of the pain is probably due to the stimulation of the afferent fibers of the spinal nerve neurons (table 1).

Cramping pain in the right lower abdominal quadrant occurred only in 3 per cent of the appen-

TABLE 1.—*Statistical Case Study*

	Age, Range, Average,	Sex		Constant Pain, Umbilical or Epigastric	Constant Pain, Umbilical or Epigastric with Shift to Right Lower Quadrant	Cramping Pain in Right Lower Quadrant	Constant Pain in Right Lower Quadrant	Diarrhea	Nausea	Vomiting
		M	F							
Acute Appendicitis (1,050 Cases)	Range 4–75 yrs. Average 24	426	624	367 (35%)	473 (45%)	32 (3%)	176 (18%)	49 (4.5%)	990 (93%)	894 (85%)
Acute Regional Enteritis (12 Cases)	Range 16–52 Average 26	7	5	0	0	11 (91%)	1 (8%)	11 (91%)	5 (45%)	2 (18%)

dicitis patients; however, in the patients with regional enteritis 91 per cent manifested this symptom. This type of pain is attributed to bowel irritability, increased peristalsis, and inflammation of the mesentery or serosa, the latter occurring in 100 per cent of the patients with regional enteritis[4] (table 1).

In 18 per cent of the cases of appendicitis the pain was constant in the right lower abdominal quadrant. This constant pain is due to the inflammation of all coats of the appendix, and the contact of the inflamed serosa with the parietal peritoneum. Here the somatic nerve endings are sensitized, and the pain becomes more localized. Consequently, muscle guarding, rigidity, and rebound tenderness occur.[4] This same phenomenon occurs in 8 per cent of the patients with regional enteritis (table 1).

Nausea occurred in 93 per cent of the cases of appendicitis and vomiting in 85 per cent; whereas in the cases of regional enteritis, 45 per cent of occur.[4] This same phenomenon occurred in 8 per cent had vomiting (table 1).

Bockus[3] records the fact that diarrhea occurs only in about 5 per cent of the cases of acute appendicitis; in our series, 49 patients, or 4.5 per cent, had complained of diarrhea. However, in the patients with regional enteritis, 91 per cent gave the history of multiple loose bowel movements, or "diarrhea," which is in accordance with Crohn,[2] Rossmiller, and Messenger[5] (table 1).

A few words may be said about other manifestations of these two diseases. In both of them the patients usually run a low grade fever. Tenderness in the right lower abdominal quadrant is found in both and, if peritoneal irritation or inflammation is present, rebound tenderness occurs. A mass in the right lower abdominal quadrant can sometimes be felt in the acute stage of regional enteritis, but is more characteristic of the chronic stage. In our series, 1 patient had a mass.

Rossmiller and Crile[6] recommended exploration only in those patients in whom a diagnosis was not established preoperatively; more radical operations were deferred until the condition of the patient improved. They point out that, since acute regional enteritis sometimes subsides spontaneously, the patients should be given a trial of conservative treatment before more radical measures are undertaken.

The appendix can be removed safely from some, but not from all patients. When the cecum is involved, the removal of the appendix may result in a fecal fistula. The safe rule is no drainage of the abdominal cavity in patients with acute regional enteritis, for fistulas usually result.

Of our patients with regional enteritis, 11 had an appendectomy performed. One of the 11 died of uremia after a lower nephron nephrosis developed. One patient had a perforated ileum. Appendectomy was not done; the patient died on the fifth postoperative day. There were three instances of recurrences after appendectomy: 1 seven weeks after operation, the second within one and one-half years, and the third, one year after surgery. All 3 had ileotransverse colostomies, with no recurrence thereafter.

Comment

Careful inquiry will usually reveal in cases of acute regional enteritis a history of diarrhea and cramping right lower abdominal pain.

We feel that these symptoms are the features which render the differential diagnosis between acute appendicitis and acute regional enteritis possible.

Summary

1. Among 1,062 patients suspected of having acute appendicitis, 12 were found to have acute regional enteritis.

2. Cramping abdominal pain and diarrhea occurred in 91 per cent of patients with regional enteritis and in only 5 per cent of the patients with acute appendicitis.

3. Nausea and vomiting occurred very frequently in acute appendicitis and relatively infrequently in acute regional enteritis.

4. An appendectomy can be performed if the cecum is not involved in cases of acute regional enteritis.

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Diagnosis and Treatment of Syphilis*

By G. A. COOPER, M. D.
Madison

G. A. COOPER

Doctor Cooper, who maintains a private practice in dermatology in Madison, is an assistant professor of dermatology and syphilology at the University of Wisconsin Medical School. He received his M. D. degree from that institution in 1935, later taking postgraduate training at Western Reserve University School of Medicine. He is a diplomate of the American Board of Dermatology and Syphilology.

THE proper treatment of syphilis is largely dependent on the diagnosis, because a different type of treatment should be employed for the various stages, and a different dosage of penicillin may be required. The following procedure should be employed in arriving at the diagnosis:

History.—1. Obtain definite history of sexual exposure. 2. Inquire carefully as to genital, oral, or skin lesions that might suggest chancre or secondary lesions. 3. What are the results of previous blood tests and spinal fluid examinations? 4. Has there been any previous antisyphilitic treatment or previous penicillin treatment for other conditions, and, if so, how much and by whom? 5. Is there any history of miscarriages, stillbirths, premature births, sickly children, or siblings with positive blood tests?

When late syphilis is suspected, an inquiry regarding history of cardiovascular difficulty or neurologic symptoms should be made.

Recent malaria, vaccination, infectious mononucleosis, virus pneumonia, acute upper respiratory infection, brucellosis, jaundice, etc., may cause temporary false positive Wassermann reactions.

Physical Examination.—Examine carefully all areas of the skin, oral cavity, perianal, and vaginal orifices, lymph nodes, the heart, the eyes, the reflexes, and muscular coordination. Likewise, examine the liver and spleen for enlargement.

Special Examination.—1. Dark field examination of all suspected chancres, mucous patches, and condylomata may provide a diagnosis before the Wassermann reaction is positive. If the physician cannot carry out this procedure himself, he should refer the patient to someone qualified to do this examination. If such service is not available, capillary tubes may be obtained from the State Laboratory of Hygiene, which are suitable for sending this material to the laboratory for dark field examination. These examinations failing to demonstrate spirochetes should be repeated three times.

2. Serologic tests should be repeated if found positive, and in cases in which syphilis is suspected and the darkfield and Wassermann results are found to be negative, the Wassermann test should be repeated at least at weekly intervals for a period of six weeks.

3. In cases of latent syphilis, fluoroscopic examination of the heart and great vessels should be done before any treatment is started.

4. In all cases of latent syphilis, and especially in cases in which neurologic lesions are found, a spinal fluid examination is generally imperative.

5. In suspected congenital syphilis, x-ray examination of long bones is indicated to determine the presence of osteochondritis, periostitis, or areas of decalcification. If there is any involvement of the eyes, careful slit-lamp examination should be done to rule out the possibility of an interstitial keratitis.

Interpretation

Dark field Examination.—In primary, secondary, and early congenital syphilis, the dark field examination may very frequently be found positive and thus enable the physician to make a diagnosis before the serologic reactions are positive. A dark field examination is of greatest value in the early stages and may be found positive from 10 to 20 days before the blood test becomes positive.

Serologic Blood Tests.—At the present time all specimens of blood and spinal fluid are sent to the laboratory, where the blood is examined by an initial supersensitive test as detection screening. When a positive test is found, a modification of the complement fixation test is also done to be certain that it is a true reaction.

Sometimes it is desirable to run a special test known as a quantitative reaction. This test is obtained in the laboratory by serially diluting the serum with saline so that a titration reading may be obtained. This quantitative reaction is of significance only when the physician is interested in following the effects of treatment for special study. It also aids in differential diagnosis, especially when the titer is high. As has been mentioned, there are occasions when other diseases may give a biologic false positive reaction. Therefore, the physician should be very careful to rule out such possibilities before assuming that the patient has syphilis.

The serologic reaction usually becomes positive between the fourth and sixth week after infection. It usually remains positive until the patient has been

* Paper prepared by G. A. Cooper, M. D., Madison, for Committee on Venereal Diseases (August 1950).

adequately treated. However, in certain cases there may be a reduction of the reaction so that readings of only 1 plus or 2 plus may be obtained. As the patient grows older and occasionally as with tabes dorsalis, the Wassermann reaction may become negative in a "burned out" case. In early cases of syphilis, with the present day treatment one may expect a reversal of the serology in a period of four to six months after treatment is initiated. Some patients with early syphilis who are treated with penicillin may not have a change in the serology until as late as one year. Therefore, if adequate penicillin has been given, one should wait the required length of time before deciding on the basis of a remaining positive serologic reaction that the patient has not received benefit from the therapy.

Doubtful or weakly positive tests should be repeated, and if the reaction is still doubtful the entire problem must be evaluated, and perhaps consultation employed before treatment is instituted.

Spinal Fluid Examination.—The spinal fluid of all patients who have positive blood Wassermann reactions should be examined. It has been found that in early syphilis in many cases there is an involvement of the central nervous system at the time of the secondary eruption. To be of value, the spinal fluid examination should include the following:

1. *Cell Count:* In order to obtain an accurate cell count, this test must be performed within an hour after the spinal fluid is withdrawn. A cell count of over 10 lymphocytes per cubic millimeter is abnormal. A high cell count indicates greater tissue spirochete activity.
2. *Total Protein:* The total protein tends to parallel the cell count in active neurosyphilis. This test should be done on a fresh specimen. A normal total protein does not exceed 40 mg. per cent.
3. *Serologic Test:* In Wisconsin the serologic tests of the spinal fluid are done as a titration procedure. They are usually reported on the results of the reaction in 1 cc., 0.5 cc., 0.2 cc., and 0.1 cc. of spinal fluid and are reported positive in whatever dilution a reaction is found. An involvement showing a reaction in 0.1 cc. indicates a more severe process than that only reacting in 1 cc.
4. *Colloidal Test:* In this state the colloidal gold test is used in which 10 tubes are diluted with the spinal fluid again giving a titration reaction. A reading of 5554321000 is usually associated with paresis. A reading of 2343221000 is frequently associated with meningeal syphilis. A reading of 12333-21000 is commonly found in tabes. It is to be kept in mind, however, that such readings will be altered by treatment.

Diagnosis of Syphilis By Stages

Primary Syphilis.—All genital lesions must be suspected of being syphilitic until proved otherwise. A diagnosis of primary syphilis (chancre) is based on laboratory examinations rather than on other findings. One should not rely too much on clinical experience in establishing the diagnosis. *No treatment should be applied to the lesions until the diagnosis is definitely established.* Even a small amount of mercurochrome may cause a disappearance of the spirochetes from the primary lesions temporarily. Before a dark field examination may be considered negative, it should be repeated on three different occasions. If this test still remains negative the patient should have repeated serologic examinations at weekly intervals for six weeks and then every two weeks until three months have elapsed.

Indolent lesions about the mouth and breasts should also be considered as possibly being due to syphilis, especially if there is enlargement of the regional lymph glands.

General Control Measures

If the diagnosis of primary syphilis cannot be established, consideration must be given to chancroid, lymphogranuloma venerum, and granuloma inguinale. It is well to remember that many genital lesions are *not* due to venereal diseases. Since syphilis and gonorrhea are frequently acquired at the same time, all patients with gonorrhea who are treated with penicillin should have serologic check-ups for a period of three months to eliminate the possibility of the penicillin having masked syphilis.

Secondary Syphilis.—The lesions of secondary syphilis are varied in type. It may be said in general that any type of lesion may be found in secondary syphilis with the exception of bullae and vesicles. As a rule, the lesions most frequently found are macules, papular lesions, nodular lesions, and occasionally ulcerative and pustular lesions. Ringed or annular lesions are at times seen in secondary syphilis. Syphilitic lesions of the palms and soles are not uncommon; they may resemble psoriasis and may lead to pigmentation in the later stages.

Oral mucous membranes may show mucous patches which are usually teeming with spirochetes. The fissures about the corners of the mouth, the fissures between the fingers, and between the toes may likewise show spirochetes by dark field examination. About the genitalia and especially the perianal area are to be found the condyloma lata. All of the moist lesions are highly infectious.

The area of the scalp may show a moth-eaten alopecia.

The common systemic signs that are associated with syphilis are malaise; headaches; bone pain, particularly over the tibial area at night; generalized lymphadenopathy; sore throat; occasionally gastritis; and hepatitis, which may be confused with an infectious jaundice.

Usually at the time of the secondary infection the serologic reaction is positive. However, occasionally the development of a positive serologic reaction is delayed for as long as eight weeks after infection. It is here that the dark field examination is particularly valuable. Any skin disease especially those that are not definitely diagnosed, should have the benefit of a Wassermann test.

Latent Syphilis ("Early Latent": Disease up to four years), ("Late Latent": Disease of over four years' duration).—This is the stage of syphilis that is characterized by quiescence of the disease following the secondary eruption. During this stage the tests usually remain positive and there may be no clinical signs or symptoms. Diagnosis in this stage is usually established from the history and the positive serologic reaction and negative spinal fluid.

Tertiary Syphilis.—When the disease has been present for over four years it is said to be in the tertiary stage. During this phase the process in most patients is quiescent but may be manifested as gummas of the skin located anywhere and appearing as single or multiple indolent ulcerations. There may be gummas of the bones, especially the flat bones in the skull, particularly the nasal septum and hard palate. There may be gummas of the liver or gummas of the stomach simulating carcinoma of the stomach. In late syphilis, involvement of the cardiovascular system is frequent. This is best detected by fluoroscopic examination of the heart and great vessels. One should carefully search for the signs and symptoms of aneurysms, aortitis, and aortic insufficiency. Occasionally the serologic test may be negative in the tertiary stage.

Syphilis of the Central Nervous System.—Syphilis of the central nervous system is such a complex disease that to summarize it in brief manner is almost impossible. It may be divided into three groups —meningovascular, paresis, and tabes. In addition to this, there are a number of less common, rather bizarre lesions producing various types of paralyses. It is imperative that spinal fluid examination be done on all patients who have late syphilis. The characteristic spinal fluid changes have been discussed previously. Every patient with Wassermann-fast syphilis must have an examination of the spinal fluid. In every case of suspected cerebral hemorrhage, an examination of the spinal fluid is usually imperative. Caution should be exercised in doing spinal fluid examinations on patients over age 65, as sometimes such a procedure is not well tolerated.

Syphilis in Pregnancy.—Diagnosis of syphilis in a pregnant woman is made the same as in other patients. All lesions found in syphilis may be found at the time of pregnancy. All pregnant women should have Wassermann tests. It is usually advisable to repeat the test in a person having a negative serologic reaction at the beginning of the third trimester, to rule out the possibility of an infection after conception. The syphilitic woman is infectious and if not treated adequately is likely to have a syphilitic child at any time of the disease. During each pregnancy the patient probably should be retreated.

Congenital Syphilis.—Every child born of a syphilitic mother may be suspected of having the disease, even though the mother was treated during the pregnancy. A blood test on a newborn child of a syphilitic mother is not of significance in establishing a diagnosis in the child. The positive cord Wassermann is not conclusive evidence of the syphilis in the infant. The antibody-like substance, or reagin, passes through the placenta so that the mother's reagin will be tested in the child until the age of about 3 months. Therefore, a positive reaction in the child's blood before this time does not necessarily indicate that the child is infected. In the newborn the diagnosis may be established by the presence of skin lesions from which spirochetes sometimes can be obtained and demonstrated by dark field examination; x-ray films of the long bones usually show the characteristic changes in the epiphyses.

The presence of hepatomegaly and splenomegaly may indicate syphilis. Babies that won't gain and babies that show evidence of snuffles should be suspected of having syphilis. The child should not be treated until a definite diagnosis has been established. Late congenital syphilis (after 2 years of age) is diagnosed occasionally from the periostitis along the tibia or the frontal bones, by interstitial keratitis, eighth nerve involvement, or the finding of Hutchinson's teeth (second dentition). Other suggestive signs are frontal bossing, mulberry molars, and Clutton's joints. Occasionally, juvenile paresis and taboparesis are found in children.

Treatment of Syphilis With Penicillin

At the present time it appears that satisfactory results are being obtained by the use of a depot penicillin alone. There are available two types of depository penicillin: crystalline G with procaine, and crystalline G with aluminum monostearate. Either type may be used.

It appears that the minimum effective dose of penicillin for early syphilis is 2,400,000 units. Present studies indicate that a depot type of penicillin of 300,000 units given daily for 10 days is adequate for a high percentage of cases. Studies do indicate, however, that relapse will occur in a certain percentage of patients treated with even larger total doses.

The best results are obtained in the seronegative primary cases. In this group, approximately 90 to 95 per cent of the patients are cured. After the serologic reaction becomes positive, the rate of cure falls to approximately 85 per cent. The latter is also true for patients with secondary eruptions.

Persons with latent syphilis should be given 3,000,000 units of penicillin, following the same plan as shown in the outline.

Treatment of congenital syphilis can be carried out with penicillin, using appropriately reduced doses, that is, 1,200,000 units for babies. The older child can tolerate the usual dose of at least 2,400,000 units. The Wassermann reaction may reverse slowly or not at all in the late congenital case.

Pregnant syphilitic women should be given at least 2,400,000 units of penicillin as indicated in the outline. This treatment should be started as soon as the diagnosis is established. The treatment is most effective before the eighth month and should not be delayed until after delivery.

The use of penicillin for the treatment of cardiovascular syphilis still requires further study. The question of whether it is safe to begin patients with this form of syphilis immediately on full doses of penicillin or whether they should first be prepared with potassium iodide and bismuth, has recently been reopened. The Herxheimer reaction is rare but when it does occur it can give rise to alarming symptoms. Until these questions are answered it is recommended that if penicillin is to be used, the patient should be prepared for this treatment by receiving 15 drops of potassium iodide three times daily; also a weekly injection of bismuth subsalicylate for a period of six weeks. Following this, the patient may be given 5,000 units of penicillin for two days. Beginning on the third day, 20,000 units should be administered for two days; on the fifth day, 50,000 units in two injections (total of 100,000 units) should be administered. Then daily doses of 300,000 units should be given, until a total of 4,000,000 units has been reached.

Central nervous system syphilis, according to present experience, requires at least 9,000,000 units of penicillin given over an adequate period of time. Recent studies indicate treatment by penicillin alone is as effective as that by penicillin combined with other forms of treatment, including fever. It is recommended that neurologic consultations be obtained.

Reactions to Penicillin Treatment

Reactions occurring following the use of penicillin are usually of two orders: (1) an allergic reaction to the penicillin which is usually manifested by urticaria or an angioneurotic edema. As a rule, one of the antihistaminic drugs is sufficient to combat this. In an emergency adrenalin may be used. (2) Herxheimer reaction—This is a systemic reaction, febrile in nature, and frequently producing an exacerbation of existing lesions. It usually occurs about four hours after the first injection of the penicillin. This can be treated symptomatically and causes no harm providing there are no focal reactions in the brain or cardiovascular system. These focal reactions are dangerous; it is for this reason we avoid the use of penicillin in late syphilis until the patient has been adequately prepared by some milder acting drug, as bismuth, for a period of a month or two months before the use of penicillin is started.

Effect of Penicillin Therapy on the Serologic Reaction

In early syphilis, that is, primary seronegative and seropositive primaries, it is usual for the serology to remain negative, or to begin to reverse at the end of about four months. Complete reversal usually occurs by the seventh month. In the cases of secondary syphilis, reversal of the serology is less rapid, and complete reversals may not occur until the end of the tenth month or even one year. If there has been no decrease in the titer after the end of the sixth month, the patient should be carefully checked for relapsing lesions of the skin which usually are infectious.

Retreatment in primary and secondary syphilis should not be considered until after one year's time or unless there is a clinical relapse. If the Wassermann is still positive after 12 to 18 months, an evaluation through consultation is recommended before retreatment is instituted. Remember that reinfection is much more frequent than has been suspected in the past.

The effectiveness of penicillin in syphilis therapy and its ease of administration has made every physician's office a potential "rapid treatment center" for syphilis control. The control of syphilis is based primarily upon the subjecting of infectious patients to treatment for the purpose of removing the infectious reservoir. However, the infectious reservoir does not consist only of those persons presenting themselves for diagnosis and treatment. For every infectious person there must be a source and often one or more infected contacts. Failure to investigate infectious syphilis sources and contacts may lead to the spread of the disease to other patients or to re-infection of the first patient. Failure to investigate syphilis sources and contacts, therefore, is unfavorable for the patient, is not fair to the contact, and does not reduce the infectious reservoir.

The Committee on Venereal Diseases has given considerable thought to the matter of reducing syphilis in Wisconsin and has agreed that epidemiologic study and contact tracing by physicians rendering treatment are of paramount importance. The decision on methods to be used in locating contacts and bringing them to diagnosis must rest with the doctor; however, if he is in need of assistance, a request to the local health department or nurse, or to the Wisconsin State Department of Health will result in a careful, discreet and cooperative investigation of contacts and sources.

The commitee also wishes to point out that as an aid to reducing syphilis the Wisconsin State Board of Health makes available upon physician's request penicillin and other drugs for the treatment of reported cases.

Retroperitoneal Lipomata

Report of Two Cases

By JOHN L. FORD, M. D., and V. J. HITTNER, M. D.
Green Bay *Seymour*

J. L. FORD

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V. J. HITTNER

A graduate of the University of Wisconsin and Rush Medical College, Doctor Hittner is the owner of the Hittner Clinic in Seymour. He is a fellow of the American College of Surgeons and the International Academy of Proctology and a member of the American Association of Railway Surgeons and the International College of Surgeons.

BECAUSE of their infrequent occurrence and because of the nonspecificity of their symptoms, retroperitoneal lipomatous and myxomatous tumors present a difficult presurgical diagnostic problem. They are characterized by ability to attain a large size, relative rapidity of growth, absence of specific symptoms, and tendency to recurrence.

Following is a report of the largest retroperitoneal lipoma encountered by both authors and also a report of a retroperitoneal lipoma in a child observed by one of us (J.L.F.).

CASE 1.—The patient, a white male aged 72, was first seen Feb. 6, 1949. His chief complaints were gradually progressive weakness, anorexia, dyspnea, weight loss, and enlargement of the abdomen. A year and a half prior to this visit, he had been examined radiologically elsewhere and had been told he had an abdominal cyst. Physical examination revealed an aged, slender man with an enormous, rounded, nonsensitive, smooth abdominal mass which appeared to be more to the left of the midline. Examination of the chest revealed a moderate cardiac enlargement, a soft murmur in the mitral area, and moist rales in the bases of both lungs. The blood pressure was 150/70. Laboratory findings were negative except for a mild hypochromic secondry anemia. Roentgenologic studies revealed a large, rounded, retroperitoneal left-sided mass which was considered to be, possibly, a pancreatic cyst, after renal involvement and cysts of the mesentery and omentum had been ruled out.

Presurgical treatment included digitoxin, whole blood transfusions, and a high caloric diet. An operation was performed Feb. 10, 1949. A vertical left rectus incision was made; the stomach and intestines were retracted to the right; the posterior peritoneum was incised; and a large rounded lobulated mass was encountered, freed, and excised. The posterior peritoneum and anterior abdominal wall were closed. Postsurgical treatment included whole blood transfusions, intravenously administered glucose, and oxygen given intranasally. His postsurgical course was smooth, and he was discharged from the hospital (St. Vincent's) on March 16, 1949.

Pathologic examination of the tumor revealed a large, lobulated, and encapsulated mass which measured 35 by 22.5 by 10 cm. and which weighed 3,271 Gm. The parenchyma had a fibrofatty and myxomatous appearance. Yellow adipose tissue was scattered diffusely and irregularly throughout. The lipomatous tissue appeared to predominate. The subcapsular vessels were markedly engorged. No pancreatic tissue or other organ tissue could be identified. Micro-

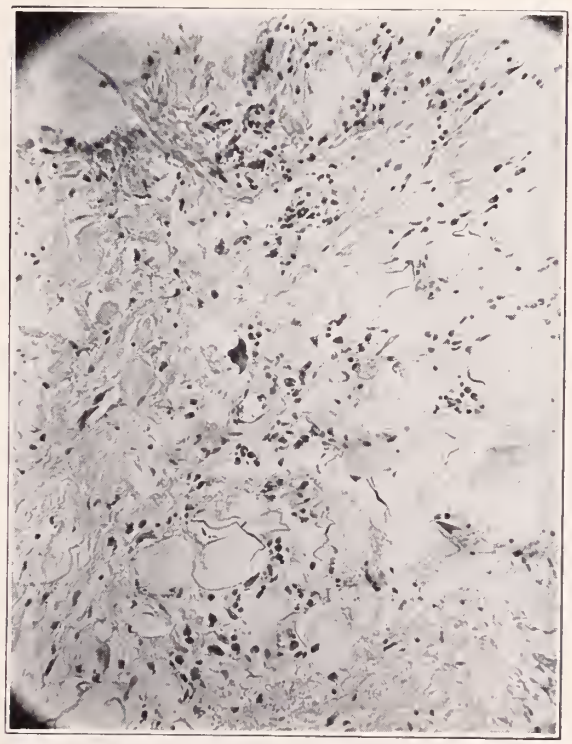

Fig. 1 (case 1).—Microscopic section showing lipoid cells in various stages of degeneration.

scopic examination (fig. 1) showed an admixture of fibrous tissue, adipose tissue, and myxomatous material. Scattered diffusely throughout all sections were numerous plasma cells and occasional collections of lymphocytes. The capsule was composed of linear strands of fibrous tissue containing numerous engorged capillaries and a few scattered areas of hemorrhage. In some areas the fibrous tissue was arranged in rather compact bundles intermixed with adipose tissue, while in other areas the fibrous tissue was intermixed with myxomatous tissue. In the myxomatous areas the fibrofatty bundles were widely separated. There was no evidence of malignancy in any of the sections examined. The tumor was considered to be a benign lipoma undergoing myxomatous degeneration.

Case 2.—M.E.G., a white female child aged 7 years, was first seen by a physician after injuring her right leg. The physician noticed some swelling of the abdomen, and, on questioning the parents, discovered that the parents had noticed some swelling since the child was a baby. X-ray examination of the injured leg revealed a pathologic fracture of the right tibia in its proximal third at the site of an osteolytic lesion 2.7 cm. by 1.2 cm. Pyelography revealed a left-sided mass 12 cm. by 14 cm. which distorted the calices. The calices appeared to be present in the inferior pole of the mass. The pelvis of the left kidney was not visualized. The right kidney and bladder were normal. The chest and upper extremities were normal. The roentgenologic possibilities included Wilm's tumor, epidermoid cyst, teratoma, lymphatic cyst, enteric cyst, and pancreatic cyst. A therapeutic trial of x-ray radiation, total 2000 roentgen units, was given through two portals, anteroposterior and posteroanterior, without results.

At operation a transperitoneal approach revealed a large encapsulated cystlike mass distinctly separated from the left kidney. The mass was excised and a Penrose drain was brought out laterally. The abdomen was closed.

Pathologic examination revealed a large, irregularly rounded, encapsulated, whitish, cystlike mass, which weighed 5 pounds and which measured 17 by 16.5 by 11 cm. The surface was roughened by coarse fibrous bands. A large amount of yellowish brown fluid containing granules of coagulated blood was present in the cystlike cavity. The cystlike cavitation contained numerous trabeculi of myxomatous-like tissue. In the thickest portion the myxomatous tissue had a yellowish color and a mottled hemorrhagic appearance. Portions of the parenchyma were spongelike, but all had a lipoid or myxomatous appearance. The capsule measured not over 3 mm. in thickness. Microscopic examination (fig. 2) revealed irregular groups and masses of embryonal lipoid cells distributed irregularly throughout a myxomatous stroma. There was some variation in the staining quality of the cells, apparently because of the variations in their degree of degeneration. The capsule was composed of linear strands of fibrous tissue. There was no evidence of malignancy. The pathologic diagnosis was benign lipoma, undergoing myxomatous degenerative change.

The osteolytic lession in the tibia could only be considered to be a benign cyst in the light of the microscopic appearance of the retroperitoneal tumor. The postoperative course of this patient was uneventful, and she was discharged on the ninth postoperative day. The last follow-up report of the above 2 cases indicated no apparent recurrence.

Comment

These lipomata of the retroperitoneal space have a tendency to grow to large size and may undergo degenerative change, usually due to strangulation of the pedicle. When strangulation occurs they become edematous and have a pseudomyxomatous appearance. This strangulation also produces vascular engorgement, areas of hemorrhage, and occasionally necrosis. The lipomata, here reported, had a typical pedicle. We believe the myxomatous changes in the tumors we encountered were due to deficient blood supply, secondary to the large size of the tumors and their relative rapidity of growth. Livermore reported a large lipoma with fibromyxomatous degeneration which weighed approximately 18 pounds and cited Young's case of a retroperitoneal lipoma which weighed 75 pounds. Regan, Sanes, and McCallum reported 7 cases of retroperitoneal lipomata in patients ranging in age from 41 to 83. These same men stated that there were 51 cases reported in the American literature from 1933 to 1943. From a perusal of the literature it appears that these tumors occur usually in women after the age of 40.

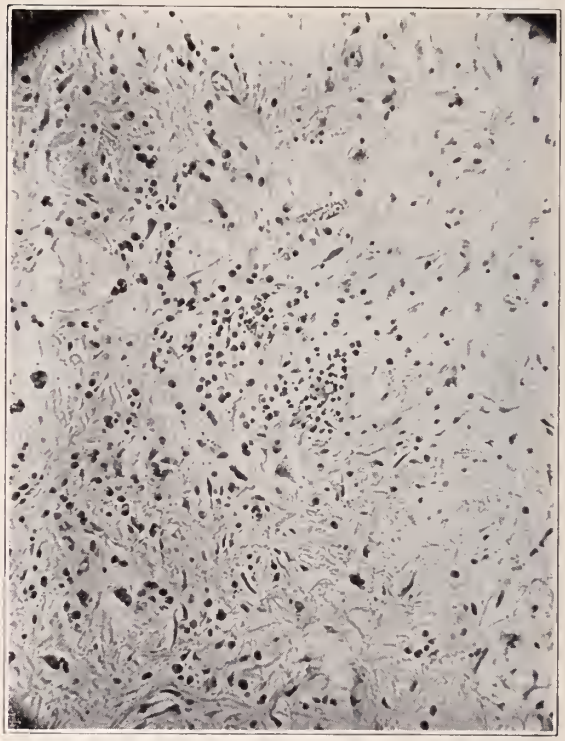

Fig. 2 (case 2).—Microscopic section showing embryonic character of lipoid cells.

Diagnosis

The usual presenting symptom is abdominal enlargement. There are usually no subjective symptoms. Pyelography is the most valuable diagnostic aid insofar as the location of the tumor in the retroperitoneal space is concerned, but usually the true nature of the mass can be determined only by pathologic examination.

Treatment

Because of the inaccuracy of the preoperative diagnosis of these retroperitoneal masses, it is al-

ways well to try a course of deep x-ray therapy to determine the relative sensitivity or nonsensitivity of the tumor. If there is no response to irradiation, one is justified in performing immediate operation. Livermore agrees with OcKuly and Douglass that postoperative irradiation be given. A search of the literature fails to reveal a sufficient number of cases which have been followed up, after preoperative and/or postoperative x-ray therapy, to make any positive statement as to the relative value of irradiation.

Prognosis

The prognosis is usually considered to be poor in these cases, chiefly because of the frequency of recurrence, but also because of the rather high operative mortality rate. Geschickter believes the lipomata with fibrous degeneration and the embryonic lipomata have a marked tendency to recur. He reported 18 cases with 9 recurrences. Putzi (quoted by Lind) up to 1926 considered the operative mortality rate to be approximately 7.5 per cent. It is quite probable that this rather high percentage has been considerably decreased since that time, because of the marked improvement in preoperative preparation, anesthesiology, and postoperative care.

Summary

Two cases of retroperitoneal lipomata are reported. Their occurrence, diagnosis, treatment, and prognosis are briefly discussed.

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UNIVERSITY OF WISCONSIN MEDICAL SCHOOL PRESENTS POSTGRADUATE COURSE

The University of Wisconsin Medical School has announced that a postgraduate course in cardiology will be presented on November 28–30. Dr. Herman Shapiro, associate professor of clinical medicine is in charge of the course.

As in past courses on the subject, a major portion of the instruction will consist of practical applications of the disciplines of cardiography through the medium of ward rounds, electrocardiographic interpretation, orthodiascopic examinations and clinical consultation on cardiac cases. Each one of the three forenoons will be spent in practical work in cardiology at the cardiology department of the State of Wisconsin General Hospital.

The afternoon hours will be devoted to lecture and quiz session presentations covering recent advances in this field. Every attempt will be made to incorporate in the lectures information of practical value to the practicing physician.

Advance registration for the Postgraduate Course in Cardiology is required in order that plans can be completed for the proper conduct of the course. The fee for the course is $10.00.

Hotel reservations may be made individually by writing to the Hotel Loraine in Madison. The hotel requests that you specify time of arrival and number of days for which you wish to make your reservation. Please mention your connection with this course in making your reservation.

The Vaginal Smear: Its Value in General Practice

By JOHN B. MIALE, M. D. and JAMES A. GUNN, M. D.
Marshfield

J. B. MIALE

Doctor Miale graduated from the University of Rochester School of Medicine and interned at the Strong Memorial Hospital, Rochester, N. Y. He served as resident pathologist and pathologist to the Brady Urological Foundation at the Cornell Medical College and New York Hospital, New York, and later as instructor in pathology at the University of North Carolina Medical School. He is now pathologist and director of laboratories at St. Joseph's Hospital and the Marshfield Clinic, Marshfield.

J. A. GUNN

Doctor Gunn is a graduate of the University of Wisconsin Medical School. He interned at St. Joseph's Hospital, Marshfield, and then served a residency in pathology with Doctor Miale. He is at present a resident in radiology at the University Hospital, Ann Arbor, Michigan.

NUMEROUS reports have been published from large and outstanding medical centers confirming the value of the vaginal smear technic in the diagnosis of carcinoma of the uterus. The value of cytologic diagnosis has been definitely proved, and it is not our purpose to contribute another confirmatory report.

We feel that the diagnostic and therapeutic services available to the average patient with cancer should not be measured by the achievements of special cancer centers, but rather by the type of service given to these patients by general practitioners at smaller general hospitals, which, it must be admitted, far outnumber the large medical centers. Until so proved, it is unwarranted to assume that a certain technic is equally useful and successful in the two types of institutions. It is for this reason that we feel this report to be justified.

Methods and Results

Although over 1,000 cases have been studied in our laboratory by the vaginal smear technic, we have chosen for this study the first 400 cases in which the vaginal smear diagnosis could be compared with the tissue diagnosis available from biopsies or surgical specimens. The smears represent cases in which women were examined routinely at the clinic or the hospital regardless of whether or not they had gynecologic complaints. In this sense the entire group of over 1,000 cases is unselected. The 400 cases used for analysis, however, represent some degree of selection, since in these cases tissue was available for diagnosis either because a biopsy was suggested or because there was some other indication for pelvic operation.

The smears were obtained and stained according to Papanicalaou's method.[1] Three types of diagnosis were returned: (1) "No evidence of malignancy," in cases in which the cytology was interpreted as being normal; (2) "No definite evidence of malignancy, but suggest biopsy and dilatation and curettage, a diagnosis made reluctantly and only when the cytologic features were suggestive but not definitely enough to warrant making the third diagnosis; or (3) "Suggestive of malignancy," in cases in which the cytologic criteria for malignancy were clearly established.

Table 1 summarizes the diagnosis made cytologically and histologically.

TABLE 1

Group I. Diagnosis "*No evidence of malignancy.*"	
Total cases	378
Carcinoma present on biopsy	2
Group II. Diagnosis "*No definite evidence of malignancy but suggest biopsy and dilatation and curettage.*"	
Total cases	6
Carcinoma present on biopsy	2
Group III. Diagnosis "*Suggestive of malignancy.*"	
Total cases	16
Carcinoma present on biopsy	13
False positive diagnosis	3

In group I the diagnosis of "no evidence of malignancy" was made in 378 cases. In this group, 2 cases of carcinoma were later found. In 1 (case 13, table 3) there was blood-tinged leukorrhea, and a biopsy and dilatation and curettage were done, revealing a carcinoma in situ of the cervix. In the other (case 14, table 3) there was a large polypoid erosion of the cervix which, when biopsied, was diagnosed as squamous cell carcinoma.

In group II there were 6 cases, of which 2 were carcinoma. One was a very early squamous cell carcinoma in a 32 year old woman (case 15, table 3); the other was an adenocarcinoma of the corpus uteri in a 60 year old woman, who also had fibromyomas of the uterus (case 12, table 3).

In group III the diagnosis of "suggestive of malignancy" was made in 16 cases. There are 13 proved carcinomas in this group, while in 3 cases the tissue sections showed no evidence of malignant growth. These 3 cases are still being followed closely, and 1 case particularly continues to show abnormal cells in the smear.

Table 2 shows that in the whole group there were six false negative smear diagnoses (group II diagnoses are considered as negative), for a false negative percentage of 1.5. In the 400 cases, there were three false positive diagnoses (0.75 per cent).

TABLE 2.—*Over-all Accuracy of Vaginal Smear Diagnosis According to Final Diagnosis*

Total cases		400
Carcinoma present		17
Cervix	12	
Corpus	3	
Other	2	
No malignancy present		383
False negative by smear		4
False negative per cent of smears		1%
False positive smears		3
False positive per cent of smears		0.75%
Total error		1.75%

There were 17 carcinomas present in the series, of which 15 were uterine, one was extension from ovarian carcinoma, and one extension from adenocarcinoma of the rectum. The 15 primary carcinomas are summarized in table 3. Of particular interest are the patients with no unusual clinical symptoms, who had positive smears and who were found to have carcinoma on biopsy.

TABLE 3

Case	Age	Symptoms	Smear Diagnosis	Biopsy Diagnosis
1	56	None	Positive	Carcinoma of endocervix
2	45	None	Positive	Carcinoma of endocervix (in situ)
3	28	Vaginal bleeding	Positive	Squamous cell carcinoma of cervix
4	33	Vaginal bleeding	Positive	Squamous cell carcinoma of cervix
5	65	None	Positive	Adenocarcinoma of endocervix
6	42	Premenstrual spotting	Positive	Adenocarcinoma of corpus uteri
7	53	None	Positive	Squamous cell carcinoma of cervix
8	61	Irregular menses; slight cervical erosion	Positive	Squamous cell carcinoma of cervix
9	58	Spotting	Positive	Squamous cell carcinoma of cervix
10	54	None	Positive	Recurrent squamous cell carcinoma of the cervix
11	68	Vaginal bleeding	Positive	Squamous cell carcinoma of cervix
12	60	Postmenopausal bleeding, once	No definite evidence of malignancy but suggest biopsy	Adenocarcinoma of corpus uteri
13	40	Blood-tinged leukorrhea	Negative	Carcinoma in situ of the cervix
14	40	Cervical polyp	Negative	Squamous cell carcinoma of cervix
15	32	Leukorrhea	No definite evidence of malignancy but suggest biopsy	Squamous cell carcinoma of cervix (in situ)

Discussion

Earlier diagnosis and treatment of uterine cancers offer the only hope at present of reducing the number of patients dying from this disease. There is no doubt that the most favorable cases are those in which the lesion has not yet produced characteristic signs and symptoms. It is not possible to submit every woman routinely to periodical biopsy and curettage, but the vaginal smear technic worked out by Papanicalaou [1] is atraumatic and inexpensive, and its reliability has been amply confirmed. [2-9]

Aside from its general diagnostic importance, the smear technic has resulted in the frequent identification of cancer in the "pre-invasive" stage. This in situ phase in the development of cancer can, of course, be discovered by fortuitous biopsies or sections, and our early knowledge came from such cases. [10-13] Well substantiated reports are found [14, 11, 12, 15] in which preinvasive carcinomas were diagnosed by biopsy as long as eight and one-half years before they became clinically evident. Pund and Auerbach [16] found 47 cases of unsuspected pre-invasive carcinoma of the cervix in 1,200 uteri removed for reasons other than cancer. The average age of the women in this group was 36.5 years, while the average age in 50 manifest cancer cases was 48.5 years. A similar difference of about 12 years was found by Te Linde and Galvin. [13]

The suggestion is obvious, therefore, that women may harbor pre-invasive (and probably curable) cancer for several years before it becomes clinically manifest and fairly well advanced. It is here that the smear technic is of greatest value in directing attention to the presence of such a lesion in a clinically well patient. Several of our cases were of this type.

In our 400 cases there was a total of 17 cases of cancer, of which 15 were primary in the uterus. Correlation with the smear diagnosis in these cases (tables 1 and 2) shows a total error of 2.25 per cent. This is merely an approximation, since, (1) the negative cases have not been followed for a sufficiently long time, (2) the biopsy diagnosis is by no means 100 per cent reliable [17, 18] and (3) some carcinomas apparently do not shed cells into the vagina. [19] Nevertheless, this percentage of error is in the range of 1.5 to 4 per cent reported by others. [20, 2, 4, 5, 8, 21]

Statistically, at least, our experience indicates that the vaginal smear technic is as reliable in general clinic and hospital practice as in larger specialized centers. However, several points remain to be emphasized.

In the first place, over 600 cases have not been considered here because the smear diagnosis has not been substantiated by biopsy. In the majority of these cases the diagnosis was negative for malignancy, and in most of them no other smears have been taken. It is a real question whether or not

these single negative reports lull us into a feeling of false security. We can certainly expect that some of these patients either have or will have cancer, and it would seem desirable to repeat vaginal smears at least every 6 to 12 months.

Secondly, some patients whose conditions were diagnosed as suggestive of malignancy by the smear have not returned for further study. It is interesting to note that some of these have been women examined free of charge at the local cancer detection center. In any case, these women represent potential cancer deaths, and in their cases, at least, little has been accomplished by studying the vaginal smear.

Also, we soon found it necessary to agree on a standard technic for obtaining cervical biopsies. Early in our series the surgeons were often baffled by a normal-appearing cervix in a patient having abnormal cells in the smear. We have since adopted the four-corners technic suggested by Ayre[22] and by Foote,[23] and the surgeon is careful to include the endocervical canal in each specimen. Cautery or conization, if any, is done only after the knife biopsy specimens have been taken.

Lastly, the general practitioner should revise in his own mind the expected symptomatology of uterine carcinoma. In 5 of our cases, a diagnosis of carcinoma was not entertained clinically, and, indeed, there were no striking gynecologic complaints. Vaginal bleeding was present in only 5 cases, and in only 1 case was the cervix clinically suggestive of malignancy. In the remainder, the primary clinical diagnosis was chronic cervicitis or cervical erosion.

We feel, in conclusion, that the vaginal smear technic is as useful and reliable for the general practitioner having good diagnostic facilities as it is in our largest and most specialized medical centers. With increased cancer-awareness and with good patient cooperation, the general practitioners, who see by far the greatest number of patients, can contribute a great deal to the early diagnosis and treatment of cancer by availing themselves of this technic.

Summary

1. The need for earlier diagnosis of uterine carcinoma is emphasized.

2. An analysis of 400 cases is presented, and the results of the vaginal smear are correlated with the clinical and histologic findings.

3. It is concluded that the vaginal smear technic is a reliable diagnostic method in general practice and in medium-sized general hospitals. By appreciating its value, contribution of the general practitioner to early cancer detection can far exceed that of any other medical group.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
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Use of Analeptics in Treatment of Poisoning by Barbiturates

There is much confusion in recent literature regarding the management of patients in coma following the ingestion of barbituric acid derivatives. Advocates of one or another of the drugs which produce central nervous system stimulation, central nervous and cardiovascular stimulation, or those producing reflex activity and others influencing metabolism usually support their opinion by citing cases in which human beings were successfully treated. Such case reports are often of little value because the degree of poisoning is difficult to determine. A given dose of a barbiturate may produce widely variable effects in different individuals. It is unjustifiable to assume that recovery would not have been complete without the drugs used, and finally one cannot always differentiate the effects of such stimulant drugs from other therapy such as supportive procedures, carbon dioxide, etc., or explain the failures because treatment other than with analeptic drugs was omitted. There is a fairly prevalent, but erroneous, opinion among physicians that every patient is dangerously poisoned who cannot be aroused readily subsequent to the known ingestion of an hypnotic drug. Frequently, temporarily nonarousable patients are taken from the operating room after having received large amounts of barbiturate. Such a condition is well described as anesthesia. If found in his bathroom in a similar condition, he is "dangerously poisoned." It would simplify reporting cases and evaluating drugs if every patient thought to be poisoned from a barbiturate could be given a trial dose of a potent stimulant or analeptic at the outset. If 10 cc. of metrazol were injected intravenously within a period of two minutes without return of reflexes or other responses, it would indicate the probable need for analeptics. If there was a response one could assume a good prognosis with or without an analeptic.

When analeptics are desirable to hasten recovery when the patient is not severely poisoned, good results can be expected from certain of the sympathomimetic amines, such as amphetamine, d-amphetamine, or desoxy-ephedrine. When analeptics are to be used to prevent death the potent analeptics are in order. Those under usual consideration include metrazol, picrotoxin, and the very questionable coramine. Picrotoxin is the most potent of the group, but it is also most dangerous in inexperienced hands and should be used only by those fully aware of its potentialities. The statement has been made that picrotoxin causes a depression subsequent to its therapeutic use. The writer can state that the so-called subsequent depression could be expected to follow convulsive effects of overdosage but not of doses properly adjusted to the individual case. The writer has successfully employed therapeutically 9 Gm. of picrotoxin within a period of a week without evidence of depression due to picrotoxin. Convulsions due to overdosage cause the exhaustion.

Metrazol is also useful when given in effective amounts, although both laboratory and clinical data tend to support the view that it is less potent than picrotoxin. There is little conclusive evidence in the clinical literature that coramine has any life-saving value in treating severe barbiturate poisoning. There are, however, considerable data to the effect that it produces a secondary and even more profound depression. This latter effect is well established in laboratory experiments.

Metrazol is thought by some physicians to be a "short actor," i.e., a drug that is short in its duration of action, presumably due to its quick destruction. This is not the case. What really happens is that, owing to the high solubility of this drug, it will only produce early central effects in small doses when given rapidly. Rapid injections produce a wave of high concentration which reaches and stimulates the brain and medulla. By slow and steady administration, the drug becomes rather evenly distributed throughout the blood and tissues so that an effective concentration can be reached, effecting a continued action for one or two hours.

One must never overlook the established fact that the treatment of severe barbiturate poisoning cannot be expected to be completed solely by the use of analeptics. Initial or early gastric lavage, maintenance of a free airway, administration of oxygen, and maintenance of body temperature are additional procedures which may be of very great importance in the treatment of poisoning by barbituric acid derivatives and other hypnotic drugs.—E. A. Rovenstine, M. D., *professor and chairman, department of anesthesiology, New York University–Bellevue Medical Center, New York.*

ACADEMY OF DERMATOLOGY AND SYPHILOLOGY TO MEET IN CHICAGO

The ninth annual meeting of the American Academy of Dermatology and Syphilology will be held in Chicago, December 2–7. The principal sessions will be held at the Palmer House, with special courses scheduled for presentation at the medical schools of the University of Illinois and Northwestern University. Extensive scientific and technical exhibits will be set up in connection with the meeting.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Disease or Symptom

Selye states that the *adaptation syndrome* has a three point life history, namely, stage of alarm reaction, stage of resistance, and the stage of exhaustion. Major clinical findings may, therefore, be variably expressed in such a syndrome but it is generally considered "body as a whole" disease as evidenced by morphologic, chemical, and clinical criteria. In a similar line of thought, Klemperer proposes a new concept of the pathogenesis of several diseases heretofore, in our thinking, unrelated. These may now be called *collagen diseases*. Selye's basic evolution of disease and Klemperer's basic morphologic interpretation of similar diseases propose a new question. Is the condition, as heretofore interpreted, a disease in and by itself or is it a symptom?

In the past the focus of clinical and pathologic attention on the kidney in the presence of albuminuria, hematuria, and cylindruria led to the rather narrow diagnosis of "nephritis." Although it was known that there was a generalized vascular disease, that arteriolosclerosis was seen, that edema was somehow related to vessel injury, and that myocarditis and focal necrosis were present, the disease was called nephritis. It has been perfectly understood that rheumatic fever was a lesion of the heart, of the joints, of the subcutaneous tissue, of the serosal surfaces, and of the brain, but generally this disease has been referred to as a "pancarditis." Malignant hypertension has its finding in the kidney, but are not the heart, the liver, the pancreas, the adrenals, the brain, and the retina also involved? How then does one speak of malignant hypertension as a renal disease? Disseminated lupus erythematosus is defined as a "dermatologic" disorder. However, in addition to the skin manifestations, one has morphologic evidence of serious alteration in many vessels of the body, in the kidney, in the heart, in the lymph nodes, in the spleen, in the joints, and in the complement of cells in the peripheral blood. Is it then a dermatologic disorder?

The recently introduced concept of the pathogenesis of some diseases, namely, adaptation syndrome and collagen disease, serves to focus our attention on a widespread, generally distributed disease process of the body involving particularly one type of tissue—*collagen*. The clinical evidence of a single organ being more affected than another should be identified as a major *symptom* of an over-all disturbance rather than as a primary and distinct disease situated in that particular organ. Nephritis, lupus erythematosus, myocarditis, arthritis, and renal arteriolosclerosis are symptoms of a collagen disease, more accurately identified by a connotation of a generalized disorder under such terms as hypertension, polyarteritis, or fibrinoid necrosis.

The basic alteration in many of the "body as a whole" diseases is a breakdown of collagen. The precise mechanism of its onset is unknown but in many instances it appears to be the "fire and ashes" of an antigen-antibody reaction. Although it is difficult to present concrete and unshakable evidence for a hypersensitivity phenomenon, it is, however, even more difficult to discount such a pathogenesis. There is more and more evidence accumulating to show the relationship of one such disease, polyarteritis, to a sensitivity phenomenon; more specifically in reference to clinical use of penicillin. Several cases have now come to our attention in which this historical and clinical sequence of events cannot be disputed. One may also recall the similar consideration in reference to the sulfonamides. The equally basic consideration of the adrenal-corticoid inter-relationship must also be considered.

In the active treatment of the adaptation syndrome or collagen diseases he use of cortisone, which alters the reaction of the collagen, seems to hold promise. The collagen change is evidenced by its morphologic alterations, principally by the loss of fine detail. This is represented by microscopically identified smudginess and by the alteration of its tinctorial reaction produced by a greater affinity for the eosin stain. Basically it may be called a "fibrinoid" change, since the smudginess and eosin affinity cause it to resemble fibrin. Especially important is this change as it affects the blood vessels of the body and emphasis of change in one or other organ is merely a symptom.—J. F. KUZMA, M. D.

AMERICAN COLLEGE OF CHEST PHYSICIANS SCHEDULES POSTGRADUATE COURSE

A postgraduate course in diseases of the chest, sponsored by the Council on Postgraduate Medical Education and the New York State Chapter of the American College of Chest Physicians, will be given at the Hotel New Yorker in New York, November 13–18. Members of the staffs of the New York City medical schools and hospitals will cooperate in the presentation. Applications may be made with the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois. The fee will be $50.

THE MEDICAL FORUM

PREPAID HEALTH PLANS TO BE SOLE TOPIC OF SPECIAL SESSION OF HOUSE OF DELEGATES

Shorten Service Period for WW II Reserves

Madison, Oct. 16.—Far fewer World War II reserves than anticipated will be called to active duty in the next few months, and many of those currently on active duty or yet to be called may be required to serve only three or four months rather than 21 months.

This outlook is the result of directives from the Army and Secretary of Defense Gen. George C. Marshall.

The army says that it plans to call up about 500 reservists, mostly with World War II service, while waiting for the doctor-draft to produce medical officers. However, it says 350 of them can look forward to returning to their practice after three or four months.

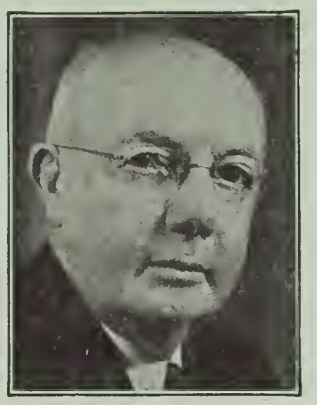
The Secretary of Defense changed the picture considerably when he ordered the Navy to call up enough of its V–12 reserves to meet the immediate requirements of all three services. The first 235 were called about October 15.

Oregon Doctors Cleared of Anti-Trust Charges

Portland, Ore., Sept. 28.—Federal Judge Claude McColloch has ruled that the medical profession in Oregon has not violated the Sherman anti-trust act in its prepaid health care plans.

The government charged that the Oregon State Medical Society, a number of county societies, and several physicians sought to monopolize the field of prepaid medical care by refusing to deal with private agencies and by disciplining physicians who did deal with them.

"I hold that the Oregon Physicians Service is not a conspiracy, but rather an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit," Judge McColloch wrote.



H. H. CHRISTOFFERSON

New President Aims at Better Public Relations for Wisconsin Doctors

Milwaukee, Oct. 3.—The new president of the state medical society Dr. H. H. Christofferson, Colby, has pledged his efforts to the improvement of medical public relations at the doctor-patient level, the support of voluntary health insurance plans and the defeat of compulsory sickness care schemes.

Improved public relations will get top billing in his program for the coming year, declared Dr. Christofferson. Speaking to the House of Delegates he repeated the admonition of Dr. Olin West in 1937, "If we ever get socialized medicine in this country, it will be the doctor's own fault."

Dr. Christofferson urged all doctors to provide adequate night and day medical service, better patient understanding of medical care and fees, and encouraged doctors to assume a large measure of community responsibility in local business, civic, educational and governmental affairs.

He also urged a medical society sponsored loan fund to help needy students get through medical school, and he pointed out that the state's two medical schools can't produce doctors beyond the present capacity level until more teaching beds, laboratories and teachers are provided.

Milwaukee, Oct. 4.—"American medicine is at the crossroads and the nation will drift into state socialism unless every doctor uses his influence to elect those who will keep America free," declared Dr. Elmer L. Henderson, Louisville, Ky., president of the AMA, at the opening session of the 108th annual meeting of the state medical society.

Before the session closed three days later 1,480 member physicians of the society and over 1,000 guest physicians, medical students, hospital personnel and exhibitors had attended the meeting.

Dr. Henderson told the doctors that "now more than ever we need unity among our ranks. This is no time to rock the boat with bickering in our own organization."

Dr. J. W. Truitt, Milwaukee, outgoing president, endorsed Dr. Henderson's remarks with the statement that "medicine's scientific endeavors will all be in vain if our freedom is lost."

On the side of official business, the House of Delegates took the following action:

1. **Rejected a move to rescind society endorsement of the Wisconsin Plan, the health insurance program endorsed by the Society and sold through private insurance carriers.**
2. **Approved a special session of the House of Delegates to be held sometime after the first of the year to consider all aspects of the prepaid health programs in Wisconsin, including fee schedules, sales territory, benefits and income levels for Wisconsin Plan, Wisconsin Physicians Service and Surgical Care.**
3. **Declared that all members of the state medical society shall be members in good standing of their county medical society and the American Medical Association.**
4. **Expressed opposition to moves by the American Hospital Association to evaluate medical staff and patient facilities as**

(Continued on page 925)

BLAST COMPULSORY INSURANCE AT CANDIDATE'S FORUM

Thomson and Kersten Expose Socialism in Biemiller Bill

Milwaukee, Oct. 3.—The "Candidate's Forum" held by the State medical society at the annual meeting on October 2 started as a well-calculated battle over the merits of compulsory sickness insurance but ended abruptly and dramatically on a "point of order."

Atty. Gen. Thomas E. Fairchild, Democratic candidate for the United States senate, and Rep. Andrew Biemiller, Democratic representative from the 5th Milwaukee district, started off with vitrolic condemnation of the American Medical Association and urgent pleas for "national health insurance."

Charles J. Kersten, Republican candidate for congress from the 5th district (the job now held by Biemiller), had blasted Beimiller's compulsory sickness insurance bill by showing that the words of the bill denied Biemiller's statements that it would give local control, no interference with doctor and patient relationship, or that it left doctors free to practice.

Assemblyman Vernon Thomson, Richland Center, Republican candidate for state's attorney general, came in late for the meeting replacing Sen. Alexander Wiley.

Thomson had just finished tracing Biemiller's Socialist background and his failure to persuade the Wisconsin people in 1937 and 1939 to accept state medicine, when Dr. J. W. Truitt, society president and forum chairman, interrupted.

Dr. Truitt said he had just received a note from Fairchild reading:

"I am going to write you (Dr. Truitt) a letter, which will be released, saying that all speakers except Vernon Thomson stayed carefully within the rules as men of honor, but Thomson, who could speak only on behalf of Senator Wiley, was permitted by you to speak, over my objections, after stating that he was not representing Senator Wiley. Thus your forum was permitted to become a platform on which Mr. Thomson could attack Congressman Biemiller without stating the views of Mr. Wiley."

Fairchild referred to the rules set forth in a letter of invitation issued to all prospective speakers. The rule provided that in case of a substitution, the substitute was to speak for the man he replaced. Thomson was substituting for Wiley, but when he began to speak, announced that he was expressing himself and not Wiley.

Dr. Truitt told Thomson that he would have to stop speaking if he was not talking for Senator Wiley. Thomson said "I will cease because I am speaking for myself," and he left the rostrum.

A. H. HEIDNER

DR. A. H. HEIDNER, PRESIDENT-ELECT

(Acceptance speech before the House of Delegates October 3, 1950)

"When I heard one of the proponents of the so-called new, or good, or fair deal have the audacity to suavely spread before us the same package of untruths, half truths and part truths that is being used to delude the American people; when I saw the ruthless boldness in the men who are spreading this cancerous growth of Socialism among our citizens; when I realized that if they succeed it will rob us and all Americans of our freedom, and eventually destroy the individual initiative which has distinguished Amercans from all others and has made us what we are today—

"I was determined that we had better forget our own minor differences for the time being, that it is high time we unite in a solid front with our money, our time and our influence to destroy this thing before it destroys us and the America we love."

But before he could leave the room, the more than 400 doctors in attendance gave him a long ovation.

Both Biemiller and Fairchild argued that "sickness insurance by compulsion" was not "socialized medicine" and that the proposed national health insurance scheme is simply a "democratic extension of the great American principle of insurance."

Kersten declared that the "advocates of political medicine would defeat by their scheme the very objective they claim to support."

"A national compulsory health insurance scheme would not extend adequate medical care, it would destroy the finest part of American medical service, its evils would fall heaviest on the American workman who would bear the brunt of its tremendous cost, it would destroy private health plans built up through the years by sound trade unions, and it would help increase the death rate because it would tie the hands with bureaucratic red tape of the men whose profession it is to combat disease and death".

He said better results can be achieved through the voluntary health insurance plans, by income tax deductions for those unemployed but able to meet the cost of prepaid plans, by extending state or local aid to the medically indigent to help them pay premiums in voluntary plans and by encouraging employer contributions toward the cost of health plans for their employees.

Thomson outlined Biemiller's record in Wisconsin and the nation. Recalling the 1937 bill for compulsory health insurance in the state legislature, Thomson said "its author had shortly before come sailing out of Eastern universities to Wisconsin as the Socialist educational director for Milwaukee County . . . He had managed the campaign for Norman Thomas as Socialist candidate for President of the United States in the Middle Atlantic states. . ."

The bill was defeated in 1937, declared Thomson, and again in 1939. He added that "the program and its proponents had been exposed and repudiated in Wisconsin and its author and only articulate advocate moved on to peddle his propaganda on a national scale."

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MEDICAL SOCIETY TAKES ITS STAND ON COMPULSORY HEALTH INSURANCE

[The following is a statement of the House of Delegates issued at the Annual Meeting, Tuesday, October 3, 1950.]

"Shall the federal government regiment all essential services of this country? Two candidates, Andrew J. Biemiller and Thomas E. Fairchild, speaking at a Candidates Forum at the meeting of the State Medical Society in Milwaukee, make it clear that the proud American Way of voluntary systems, free from compulsion, will be destroyed in this country if their views are to prevail.

"That is the road to socialism. It cannot and will not stop with medicine.

"Any person, proud of this country, proud of its record, proud to be a citizen, should rightfully now force the issue.

"Are the skilled trades—electricians, plumbers, carpenters—to become the servants of the state?

"Is collective bargaining to be abolished and government dictatorship to be substituted?

"Is the farmer to become an economic peasant in this planned society?

"Shall the professions of law, medicine, engineering and others be the exclusive services of bureaucratic government?

"Shall the business services—housing, merchandising and banking—be government monopolies?

"Voluntary efforts, as they exist today, were ridiculed and held to be ineffective and unworkable. It is useless to fight Communism and Socialism in Korea only to lose the fight at home.

"Forceful opposition was expressed by candidates Charles Kersten and Vernon W. Thomson. The State Medical Society agrees with their conclusions. It agrees that the history of the movement is the result of long-time socialist planning. It agrees that American citizenship must be preserved.

"It agrees that the issue is here and that the fight is on. It pledges its support to the philosophy that a government of the people, by the people, and for the people must be preserved."

M.D.—The U.S. Doctor Film Available Now

Madison, October 2.—Prints of the film "*M.D.—The U.S. Doctor*" are now available for showing to professional groups.

Anyone wishing to obtain this film may write the state medical society at Madison.

CANDIDATE'S FORUM . . .

(Continued from page 924)

Thomson pointed out that although the Administration's bill for compulsory health insurance is now "covered with a cloak of respectability called a welfare program," the bill now in Congress has "many paragraphs and pages that are identical with the bill presented years ago in Wisconsin by the Socialist educational director of Milwaukee county."

"With all the propaganda—with the public treasury bleeding and the President pleading—the Socialists couldn't sell this program of compulsion to their own Congress . . . They couldn't sell the idea because the people know it is as completely unnecessary in the nation as it is unnecessary in Wisconsin," declared Thomson.

SPECIAL SESSION . . .

(Continued from page 923)

part of a program of hospital standardization.

5. **Requested study of a program of group malpractice insurance for all members of the society.**
6. **Commended the state's daily and weekly newspapers and the radio stations carrying the "March of Medicine" program of the state society for "exceptional" contributions to health education.**

The House of Delegates also declared that the society will go to the 1951 legislature in a renewed attempt to secure laws permitting the erection of county infirmaries for the care of the aged.

VA Sets New Procedure for Malaria Cases

Madison, September 15.—Mr. Thomas J. Doran, Director of Wisconsin Veterans Medical Service Agency of the State Medical Society advised physicians that new procedures are necessary in connection with the examination and treatment of veterans suspected of having malaria.

Doctors are requested to follow the advice of the chief medical officer of the regional V–A office in Milwaukee whose letter to Mr. Doran is reprinted below:

"In conjunction with the examination and treatment of veterans suspected of having malaria, instructions recently received from the Central Office require that in case a positive blood smear is obtained, the prepared blood smear slide will be mailed in a suitable container to the Milwaukee Regional Office for further study and examination. The Milwaukee Regional Office is then directed to forward the blood smear slide to the Director, Veterans Claims Service, Central Office, Washington, D.C., for his study. This procedure is necessary before any further diagnosis of malaria for rating purposes may be accepted."

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MULTIPLE SCLEROSIS CLINIC TO AID PHYSICIANS

ASK PHYSICIANS TO SEND MS PATIENTS; REFERRING MD HANDLES TREATMENT

Madison.—The establishment of a multiple sclerosis clinic at the University of Wisconsin last month places another highly important diagnostic and consultant facility within the reach of every Wisconsin doctor.

The clinic, first of its kind in the strategic multiple sclerosis belt of the north central states, opened its services to doctors and patients on September 1.

Its aims to:

1. **Supply diagnostic and consultant services to Wisconsin physicians.**
2. **Evaluate ambulatory referred patients.**
3. **Study referred multiple sclerosis cases and recommend a treatment schedule to be carried out at home by the referring physician.**
4. **Conduct research by means of a multiple sclerosis registry to which physicians will report suspected or diagnosed cases.**

Because multiple sclerosis is the number one neurological problem in Wisconsin, and its incidence in the state is among the highest anywhere, the clinic was set up with the aid and approval of Dean William S. Middleton and the support of Dr. William J. Bleckwenn, chairman of the department of neuropsychiatry. It was proposed by Dr. Hans H. Reese, a member of the medical advisory council of the National Multiple Sclerosis Society.

Dr. Edward P. Roemer, Madison, was appointed director. The clinic will be open on Wednesday and Friday of each week from 2 to 5 p.m. in the Bradley Memorial Building of Wisconsin General hospital.

Patients will be admitted by oppointment only—upon referral from their physician or from public agencies in accordance with existing state regulations for admission to the hospital. The profession is invited to attend these out-patient clinics.

The clinic will operate a registry to which all physicians are requested to voluntarily report all cases of multiple sclerosis. It is believed that this registry will provide a fund of knowledge concerning the disease in Wisconsin that is not known and can not be obtained any other way.

With the cooperation of the physicians, an excellent follow-up system can be established. Any suspected multiple sclerosis cases referred to the clinic will be diagnosed and treatment schedules recommended, but all procedures will be carried out at home by the referring physician.

Because the unsolved problems of multiple sclerosis cover many specialized fields of medicine, the clinic functions will have a group of consultants available at all times.

Name Consultants

These include Dr. Hans H. Reese, coordinator of research; Edward P. Roemer, neurology; Robert Roessler and Benjamin Glover, psychiatry; Ovid Meyer, hematology; Edgar S. Gordon, endocrinology; Phillip P. Cohen, biochemistry; John W. Brown, infectious diseases; A. F. Rassmussen, virology; Helen P. Davis and S. C. Crepea, allergy; Peter A. Duehr, opthalomolgy; John L. Sims, hepathology; Harry D. Bowman, physical medicine; William Fey, psychology, and Prof. Hans Becker, sociology.

Dr. Roemer, clinic director, has issued an appeal to all Wisconsin physicians to cooperate in this venture by:

1. **Reporting suspected or diagnosed cases to the multiple sclerosis clinic for inclusion in the multiple sclerosis registry.**
2. **Referring probable, doubtful or unlikely cases to the clinic for evaluation as ambulatory referred patients.**
3. **Sending true, certain, and sure cases of multiple sclerosis for study and research investigations so that recommendations for treatment schedule can be made to the referring physician. He will carry out treatment procedures at home through his office.**
4. **Becoming affiliated members of the clinic.**

Physicians should address inquiries to Wisconsin General Hospital, Wisconsin Multiple Sclerosis Clinic, % Dr. E. P. Roemer, 1300 University Avenue, Madison 6, Wisconsin.

DR. E. P. ROEMER, DIRECTOR of the Multiple Sclerosis clinic confers with Dr. Hans H. Reese, (Right) member of the medical advisory council of the National Multiple Sclerosis Society, concerning the newly established clinic at Wisconsin General hospital.

50 Doctors Named to 1951 Committee Posts

Milwaukee.—Fifty physicians have been named by Dr. H. H. Christofferson, Colby, president of the state medical society, to serve under his direction for the coming year.

He made the appointments at the opening session of the 108th annual convention of the society Sunday, October 1.

The committeemen named are:

Cancer

Dr. A. R. Curreri, Madison, chairman
Dr. W. S. Bump, Rhinelander
Dr. L. J. Van Hecke, Milwaukee
Dr. D. C. Beebe, Sparta
Dr. S. L. Henke, Eau Claire
Dr. J. W. Conklin, Platteville
Dr. G. C. Schulte, Kenosha

Care of Crippled Children

Dr. H. A. Sincock, Superior, chairman
Dr. A. B. Schwartz, Milwaukee
Dr. R. E. Housner, Richland Center

Coordination of Medical Services

Dr. S. B. Harper, Madison, chairman

Goiter

Dr. Arnold S. Jackson, Madison, chairman
Dr. Bruno Peters, Milwaukee

Grievances

Dr. R. E. Fitzgerald, Milwaukee, chairman
Dr. E. W. Mason, Milwaukee
Dr. E. D. Sorenson, Elkhorn

Health and Public Instruction

Dr. E. R. Krumbiegel, Milwaukee, chairman

Hearing Defects

Dr. T. L. Tolan, Milwaukee, chairman
Dr. J. A. Hurlbut, Madison

Hospitals Relations

Dr. J. E. Habbe, Milwaukee, chairman
Dr. Gorton Ritchie, Milwaukee
Dr. Karl H. Doege, Marshfield

Industrial Health

Dr. D. E. Dorchester, Sturgeon Bay, chairman
Dr. C. E. Pechous, Kenosha

Maternal and Child Welfare

Dr. L. M. Simonson, Sheboygan, chairman
Dr. R. F. Purtell, Milwaukee
Dr. Amy Louise Hunter, Madison

Medical Education and Hospitals

Dr. J. K. Trumbo, Wausau, chairman
Dr. A. H. Heidner, West Bend

Mental Hygiene and Institutional Care

Dr. A. M. Christofferson, Waupaca, chairman
Dr. P. R. Minahan, Green Bay

Public Policy

Dr. C. A. Dawson, River Falls, chairman
Dr. J. M. Sullivan, Milwaukee, vice chairman
Dr. S. E. Gavin, Fond du Lac

Rural Health and Accident Prevention

Dr. M. W. Stuessy, Brodhead, chairman
Dr. M. L. Whalen, Bruce

Tuberculosis

Dr. J. D. Steele, Milwaukee, chairman

Medical Service and Public Relations

Dr. T. D. Elbe, Thiensville, chairman
Dr. John Smith, Milwaukee

Visual Defects

Dr. J. B. Hitz, Milwaukee, chairman
Dr. H. J. Belson, Manitowoc

Scientific Work

Dr. P. A. Midelfart, Eau Claire

Wisconsin Physicians Service Directing Board

Dr. E. M. Dessloch, Prairie du Chien, chairman
Dr. John Sprague, Madison
Dr. John Truitt, Milwaukee

Special Committee on Medical Care Survey

Dr. R. H. Quade, Neenah, chairman
Dr. J. H. Houghton, Wisconsin Dells
Dr. N. F. Dettmann, Milwaukee
Dr. Rogers Garrison, Wisconsin Rapids
Dr. Robert Krohn, Black River Falls

The committee members appointed by Dr. Christofferson are those whose terms expired or who are new appointees.

Doctors Honored for 1,000 Years of Service

Madison.—Twenty veteran Wisconsin physicians who have practiced a total of more than 1,000 years were honored at the annual convention of the State Medical Society in Milwaukee on October 3.

They were initiated as members of the "50 Year Club" which already includes 86 physicians who have served their communities for more than half a century.

The new members are Doctors:

G. R. Baker, Tomahawk; Hart Beyer, Pittsville; C. A. Cooper, Colfax; L. E. Fazen, Racine; F. P. Foley, Dorchester; J. A. Junck, Sheboygan; H. H. Kleinpell, Prairie du Chien; A. W. Ladewig, Milwaukee; C. W. Leonard, Fond du Lac; W. N. Linn, Oshkosh;

J. V. May, Marinette; L. A. Moore, Monroe; F. G. Peehn, Sturtevant; E. T. Rathert, Chilton; Felix Schmit, Wauwatosa; J. F. Smith, Wausau; S. B. M. Smith, Wausau; I. F. Thompson, Beloit; Donald Waters, Wisconsin Rapids, and D. E. W. Wenstrand, Milwaukee.

A member of the State Medical Society automatically qualifies for membership in the "50 Year Club" when he has actively practiced medicine for at least 50 years.

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FIRST RURAL HEALTH MEET A SUCCESS; ASK FOR MORE

Farm People and Doctors Find Exchange of Ideas Revealing and Helpful

Green Lake, Sept. 23.—The first Wisconsin rural health conference, sponsored by the state medical society and 55 other statewide organizations, was a spirited session that provided a much-needed meeting of minds between the medical profession and the public.

There was healthy debate on such questions as "are there enough doctors?", "how can we get a hospital in our town?", "how can we get more and better prepaid health insurance?", and "what can we do to organize for better community health?"

About 275 persons interested in rural health sat in on the discussions at Green Lake on September 22–23. All appeared to agree on one thing—the exchange of ideas and experiences and the understanding of both sides of many problems was well worth the conference. And they agreed, too, that it will take more than one rural health conference to find the answers.

Between the major speeches and the several discussion sections, the participants had an opportunity to examine almost every facet of the most important current rural health problems. Indicating the scope of the discussion are these summarized reports of the various section chairmen.

SHOULD WE TRAIN MORE DOCTORS? Oswald Anderson of the Wisconsin Farm Bureau Federation, Madison, reported for his section:

> Although there was a general feeling among the public that there are still not enough doctors, the medical profession reports that Wisconsin medical schools are operating at capacity for their present facilities and faculty. Even if more doctors are produced—and there is question as to how many more should be trained—there is no assurance that they will practice in rural areas. Communities might help by providing good clinical facilities for a doctor, and possibly the medical practice act should be modernized to permit the licensing of adequately trained foreign physicians.

ATOM BOMBS AREN'T LIKELY TO BE USED AGAINST FARM AREAS, but the big problem for farm people is to care for the thousands of refugees from cities attacked in any future war. That's the opinion of Dr. Charles Dunham, director of the Atomic Energy Commission's division of medicine and biology, center above. He's shown at the rural health conference at Green Lake on Sept. 22–23 talking with Dr. M. W. Stuessy, Brodhead. (left) conference chairman, and Dr. W. D. Stovall, Madison, conference moderator.

DOES YOUR COMMUNITY NEED A HOSPITAL? Section chairman Milo Swanton, secretary of the Wisconsin Council of Agriculture Cooperative, Madison, reported:

> There is great need for enlightenment and understandable information about hospital needs, costs, upkeep, and overall planning. Thinking about the various types of hospital services and their inter-relationship should be clarified. Intelligent local alertness and responsibility must be developed. The Wisconsin hospital survey and construction division of the state board of health is a most valuable service and should be relied upon still more in the future. This division should undertake an expanded program of public information.

ORGANIZING TO MEET COMMUNITY HEALTH NEEDS. K. W. Hones, president of the Wisconsin Farmers Union, Chippewa Falls, reported:

> Doctors and public alike should understand the difference between a public health department and a public health council. A public health department is a tax-supported arm of the government which enforces the health standards of the state and community and works in the field of sanitation, immunization and public health measures.
>
> A public health council is a voluntary, private organization of the people of the community designed to study the health needs and perform an educational job among the public in the interests of better health. Farm people, not being specialists in health and medicine, look to the state board of health and the state medical society for leadership. These two organizations have not used organized groups in Wisconsin as much as they could or should. Farm groups are ready to do much more than has been done if someone will tell them what to do.

MEETING HEALTH CARE COSTS THROUGH PREPAID PLANS. William Seffern, master of the Wisconsin State Grange, Van Dyne, reported:

> Lack of desire for health insurance is one of the main causes

for low prepaid health coverage among rural people. This is probably due to lack of proper and sufficient educational campaigns. High percentage of participation by members of the basic groups must be maintained if costs are to be kept down and benefits increased.

Need Continuous Coverage

This requires good community participation and acceptance by each participant of a measure of responsibility for success of the plan. Only about 18 per cent of the rural people have coverage, and improvements need to be made in it. However, many of the answers can be found if farmers and doctors work together to obtain continuous and wide coverage and new prepaid plans begin modestly rather than on a large, comprehensive scale.

Those who attended the conference unanimously voted for the continuation of rural health conferences in future years, and a special report of the 1950 conference is to be prepared for wide distribution.

ELECT OFFICERS AT STATE MEETING

Milwaukee, October 5.—The House of Delegates of the State Medical Society of Wisconsin named Dr. H. A. Heidner of West Bend, a councilor for more than 25 years, president-elect of the society at the annual meeting October 3–4. Dr. Heidner will take office in October, 1951.

Other officers elected were Dr. R. L. MacCornack, Whitehall, speaker of the House of Delegates, and Dr. B. J. Hughes, Winnebago, vice-speaker.

Dr. S. E. Gavin, Fond du Lac, was elected to succeed himself as delegate to the American Medical Association, and Dr. Dexter Witte, Milwaukee, replaces Dr. J. C. Sargent, Milwaukee, as the other delegate. Their alternate delegates will be Dr. L. O. Simenstad, Osceola, and Dr. Joseph Griffith, Milwaukee.

The terms of five members of the council expired at the same meeting. Three of these men, Drs. J. C. Fox, La Crosse, J. M. Bell, Peshtigo, and R. G. Arveson, Frederic, were re-elected to succeed themselves for three year terms. New members of the council will be Dr. E. E. Kidder, Stevens Point and Dr. C. E. Zellmer of Antigo.

COUNTRY DOCTOR OF THE YEAR. Dr. Spencer D. Beebe, 81-year-old Sparta physician, was named "Wisconsin Country Practitioner of 1950" by the Wisconsin Rural Health Conference. He was picked for the honor by the executive committee of the conference which included 5 laymen and 5 members of the health professions.

He is shown above (left) receiving the citation from Milo Swanton, Madison, secretary of the Wisconsin Council of Agriculture. The certificate honored him as typical of the general practitioner in the medical profession and a man whose achievements and community efforts have made him "more than a doctor."

DR. A. J. QUICK

COUNCIL AWARD TO DR. QUICK

Milwaukee.—Dr. Armond J. Quick, professor of biochemistry at Marquette University School of Medicine, Milwaukee, last night (Tuesday, Oct. 3) received the "Council Award", highest honor for scientific achievement granted by the State Medical society.

Dr. Quick received the honor at the annual banquet of the State Medical society convention at the Schroeder hotel.

He is noted for his work in the field of blood coagulation and hemorrhage, and in 1944 received the American Medical Association's "Gold Medal" for an exhibit in this field.

Dr. Quick is a native of Theresa, Wisconsin, and a graduate of the universities of Wisconsin and Illinois. He began his career as a chemist, but completed his medical education at Cornell University in 1928. After teaching there for several years he joined the staff of Marquette University.

Long a champion of the use of animals in medical research, Dr. Quick has made many contributions to medical education and research through his scientific writings to doctors and laymen.

In presenting the citation, Dr. R. G. Arveson, Frederic, chairman of the Council declared that Dr. Quick was honored for "your attainments in the science and art of medicine and surgery; your many services to humanity and, in particular, to the health and well-being of the children confined to Milwaukee Children's hospital; and for your wise and patient counseling of your fellow practitioners."

AMA Answers Question "Who is in the Reserves?"

Madison, Oct. 11.—Almost every physician with military service in World War II is asking "Who is in the reserves, and who isn't?"

It makes a difference, because for some it means they do not have to register in the "doctor-draft", and for others it means they are subject to call to active duty.

The AMA went to the Army Surgeon General and the Bureau of Naval Personnel for the answers. This is what it got:

> **"Because of the many rules and regulations involved, only the proper military authorities can give a final answer in any particular case."**

The information the AMA did get should be considered only for guidance and not for determination of status:

> ARMY: **"Reserve officer appointments or reappointments in force at the outbreak of World War II (or made subsequently) remain in force until six months after termination of the war or termination of the five-year appointment period, whichever is the later, unless specific action to terminate the appointment has been taken by the Department of the Army. Under current law in this instance, World War II has not been declared terminated."**
>
> NAVY: **"A man is still in the Naval Reserve unless: 1. He has resigned his reserve commission, or 2. He has been discharged from the reserves. The mere release to inactive duty of an officer in the Naval Reserves does not sever his connection with the Navy."**

Air Force had no separate medical service during World War II, and therefore its situation is covered by the above Army statement.

If there is any real doubt on the part of any physician as to his reserve status, the only proper course is for him to contact his Military or Naval district commanding officer.

Weston Heads Selective Service Advisory Group

Drs. Neupert and Mashek Are Other Members

Madison, Oct. 11.—Dr. Frank L. Weston, Madison, has been named chairman of the Volunteer Wisconsin Advisory Committee to State Selective Service on the selection of doctors, dentists and allied specialists.

The appointment was made by Dr. Howard A. Rusk, chairman of the National Advisory Committee to Selective Service, Washington, D.C.

Also appointed with Dr. Weston were Dr. Carl N. Neupert, state health officer, and Dr. R. J. Mashek, Milwaukee dentist.

Dr. Weston was advised that he may appoint such additional members to the committee as may be necessary to carry out its functions, and he may appoint any volunteer advisory subcommittees to serve at state and local levels as are necessary.

These may be separate committees of physicians, dentists or veterinarians to give appropriate consideration to the respective needs of the armed forces and of the civilian population for the services of the members of their respective professions.

The organization of the state committee is to get under way immediately. Dr. Rusk said it is responsible for:

1. **Maintaining liaison with the state director of selective service.**
2. **Advising the selective service system concerning the classification of individual members of the health professions who are subject to classification by selective service boards.**
3. **Carrying out within Wisconsin the policies established by the National Advisory Committee.**

Details of the committee's plans will be outlined within the near future.

All Doctors Under 50 to Register by Jan. 16

Madison, October 17.—The first registration of physicians under the doctordraft law was held on October 16.

Men in the first two categories under public law 779 were required to register at their local selective service office.

All others covered by the draft law must be registered by January 16, 1951, but the date or dates for those registrations have not yet been set by selective service.

Oct. 16 Registrants May Still Get $100 Bonus

Must Act Quickly

Madison, October 11.—Physicians who have registered under the doctor-draft law on October 16, 1950 are still eligible for the $100 per month pay bonus for services in the armed forces if they act quickly to apply for and receive a reserve commission.

This is the advice of the American Medical Association and the Secretary of Defense.

The following is a statement by the Secretary of Defense which is currently used as the authority by which physicians may receive the $100 per month bonus:

> **"Reserve commissions are now available in the Medical Corps and Dental Corps of the Army and Navy to doctors of medicine and doctors of dentistry who have the proper professional qualifications and are physically and otherwise qualified. Persons who volunteer for these commissions and are placed on active duty before being inducted under the Selective Service Act are entitled to receive the $100 per month additional compensation authorized by Congress for doctors and dentists who enter the services under the voluntary plan. This extra compensation is not available to persons who enter the services through Selective Service, even though they are subsequently commissioned.**

Supports Deferment

"These reserve commissions are available to qualified doctors of medicine and dentistry who have completed a four-year medical or dental course and are now serving their internship, as well as those who are about to start their internship. Once accepted and commissioned in the reserve they may be called for a period of active duty in the Army, Navy or Air Force after they have finished their current year of training. The acceptance of such a reserve commission, while not of itself constituting deferment from Selective Service, is evidence of the individual's willingness to serve where the Armed Forces can best use him and may be presented to the local board in support of a request for deferment."

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M; D. University of Wisconsin Medical School, Madison

Presentation of Case*

THE patient was a 29 year old, married, white female, who was admitted to hospital on January 27, 1949, because of severe pleuritic pain in the left chest.

Present Illness.—The present illness began in January 1948, when she suffered an attack of pain in the right shoulder, aggravated by respiratory movements. This subsided spontaneously in three days, but during the following five months she experienced four or five similar attacks, each time affecting the right shoulder. There was a 25 pound weight loss. Six months after the first symptoms the patient experienced severe pleuritic pain on the right, accompanied by a cough productive of blood-streaked sputum. These symptoms cleared within a week. She then felt quite well until three months later, when she had a "heavy dragging" pain in the right chest, of three weeks' duration. Following this she was in a private hospital for one month, during which time she had 14 days of penicillin therapy and 14 days of streptomycin therapy, with no improvement. There were two more episodes of right pleuritic pain, in November and December 1948, each accompanied by production of bloody sputum. In January 1949 bronchoscopic examination was negative. About ten days later, pleuritic pain on the left side was experienced for the first time, and this was associated with shortness of breath. A few days later she was admitted to this hospital.

Past History.—The onset of the menses was at the age of 16; regular 28 days; duration 4 days. In December 1946 menstruation ceased, and a month later pregnancy was diagnosed. Early pregnancy was complicated by intermittent vaginal bleeding. In March 1947 a spontaneous abortion occurred. Three months later the menses became extremely irregular, and they remained so from then on. From that time on she was unable to become pregnant.

Physical Examination.—The patient was mildly dyspneic. The thorax was symmetrical. A few rales were heard in both bases, and questionable dullness was demonstrated over the left lung base. The blood pressure was 108/78; the pulse was 100 per minute. The heart was regular in rate and rhythm, with no murmurs or enlargement. The abdomen was normal, as were also the pelvis and rectum. Mild finger clubbing was found.

Laboratory Studies, X-rays and Special Examinations.—On admission the urine showed a specific gravity of 1.021, 4 plus albumin and many granular casts. There were 4,270,000 red blood cells, a hemoglobin content of 12 Gm., and 24,300 white blood cells with 83 segmented cells, 12 lymphocytes, and 5 monocytes. Kahn and Wassermann tests were negative. The sputum was repeatedly negative by smear and culture for acid-fast bacilli and fungi. During the hospital course a mild anemia developed in the patient, and the sedimentation rate was extremely fluctuant, varying from 20 to 110. Cold agglutinins and other routine agglutination tests were negative. Blood cultures were repeatedly negative. Urine specimens repeatedly contained albumin and casts and a few red blood cells. The Fishberg concentration test was normal. Nonprotein nitrogen content was 44 mg. per cent. Liver function studies showed serum proteins at first normal; later, total proteins were 6.6 Gm. per cent, with albumin 2.7 and globulin 3.9. Otherwise, liver tests were normal. Serum bilirubin was constantly elevated, with a high of 4.2 mg. per cent in one minute and 6.6 in 25 minutes. The blood cholesterol was 158 mg. per cent and esters 37. The prothrombin time was variable, 78 to 14 per cent. Special examinations showed hyperplastic bone marrow on April 21. Tonsillar biopsy and muscle biopsy specimens were negative. Bronchoscopy on March 8 revealed marked widening of the carina. Three electrocardiographs were reported as "normal," probable right heart strain pattern, and sinus tachycardia. Allergic studies showed histoplasmin, coccidioidin, and tuberculin tests negative. Skin reactions were positive to dust, feathers, ragweed, mold, and grasses.

Clinical Course.—Throughout her hospitalization, the patient ran a low remittent febrile course, varying from 99 to 102 F. From time to time she experienced pleuritic pain, sometimes accompanied by bloody sputum. In April the dyspnea became more severe, relieved somewhat by lying flat, but not by aminophyllin. Treatment included repeated small transfusions, a course of penicillin, and a trial of Aureomycin. The antibiotics had no noticeable effect on the pulmonary lesions. She was given vitamin K for prothrombin deficiency, and antihistaminics were given a trial. Although the nutrition remained good, the course was downhill from the standpoint of increasing dyspnea. Oxygen by mask and tent were required the last three weeks of her illness. Even with oxygen, air hunger continued. On May 19 at 11:40 a.m. there developed sudden, severe cyanosis and increased dyspnea, and the patient died within a few minutes.

DR. T. J. PFEFFER (Roentgenologist): A roentgenogram of the chest on admission (Feb. 9, 1949) revealed multiple, irregular, scattered areas of increased density throughout the right lung and left lower lung fields, changes compatible with an indeterminate type of pneumonitis. Subsequent roentgenograms of the chest again showed the previously demonstrated areas of increased density in both lung fields, somewhat more marked on the left at this time. No significant pleural effusion was present. The pulmonary artery segment of the left border of the heart appeared to be more prominent than noted on previous examinations.

Chest bronchograms (March 18) were not remarkable except for a small bronchocele or bronchiectatic cavity in the right upper lung field. There was considerable resolution of the previously noted changes in both lung fields. Subsequent chest x-rays

* From Veterans Administration Hospital, Wood; Dr. M. J. Lustok, clinician; Dr. J. M. Lubitz, pathologist.

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revealed little or no change. The left pulmonary artery segment continued to be conspicuous. The cardiac shadow showed evidence of gradual enlargement up to time of last examination, on April 28. This was probably due mostly to right ventricular enlargement. Other roentgenographic examinations were without significant findings.

Dr. M. J. Lustok (internist): In preparing a clinical discussion, involving the discovery of a diagnosis, as a prelude to presentation of a pathologic report, it is difficult to avoid bias. The discussant must suspect rarity of the situation—a frequent basis for choice in clinicopathologic presentations—and finds support for such in the maze of laboratory studies presented.

I shall not reiterate the clinical observations except to re-arrange the positive and significant negative findings into categories which may point in the direction of initial approach to the problem of diagnosis. I have arbitrarily chosen the groups of infectious diseases, metabolic diseases, and degenerative diseases as the first step in an analytic approach. The age of the patient and the rapidity of progression of the clinical course excluded the degenerative disease group. We must weigh the balance of predominant evidence between the infectious and metabolic disturbances. There is much to support both.

The present history is equivocal, although the past medical history seems vitally important. Pain in the right shoulder may be due to local pathologic changes or to referred pain from diaphragmatic pleurisy secondary to either pulmonary or hepatic disease. Hemoptysis is good evidence of an ulcerative lesion of the tracheobronchial mucosa or destruction of lung parenchyma and suggests that pain in the right shoulder was a reference phenomenon from the diaphragmatic pleura and part of the same process. The drugs used necessitated consideration of allergic arteritis, and failure of clinical response to chemical and antibiotic therapy suggests that the process was not infectious in nature—at least not by ordinary strains of organisms. The past medical history is important. Service in the Pacific theater lays open the wide vista of parasitic infestation. The gynecologic history is significant. The patient apparently presented no gross evidence of endocrine dysfunction, and yet, after the first pregnancy, which was complicated by intermittent, bright vaginal bleeding and terminated in a spontaneous abortion, there developed marked menstrual irregularities and sterility, which persisted until death. Description of the physical examination was not particularly helpful to analysis.

We have a rich fruit of laboratory studies. The peripheral blood smear is noncontributory. Anemia and elevated sedimentation rate suggest a severe debilitating process. Renal findings are those of progressive failure of both glomerular and tubular functions (and suggest an extrinsic rather than primary etiology) but no azotemia. There is also evidence of suppression of hepatic functions, but no strong impression of primary liver disease. I shall not discuss the many negative laboratory findings and special tissue studies—largely those of exclusion rather than support.

The electrocardiograms and chest x-rays are very revealing. I would like to interject a thought at this point. The Chinese say it best when they remark, "A picture is worth a thousand words." This applies to electrocardiograms and chest roentgenograms as well. I do not wish to question the report as given—but I assure you that inspection of the tracings and films revealed to me a more poignant story than was intimated in the protocol. Serial electrocardiograms at first were normal and within a three month period evolved into a rapidly developing and progressive severe right heart strain pattern. This tells us that the nature of the process was such as to have caused a rapid and extensive obstruction of the pulmonary circulation with rapidly increasing pulmonary hypertension and load on the right heart. This is particularly significant when one studies the series of chest films.

Serial chest roentgenograms present evidence of parenchymal infiltrative lesions with generalized dissemination and pneumonic spread. These lesions have the peculiar characteristic of clearing rather rapidly, without residuals, to recur again at a new site. There is no evidence of bronchogenic spread—an important negative observation when one considers the possibility of endogenous dissemination. Later, there is extensive hematogenous involvement of both lung fields, irrespective of the parenchymal lesions. This series of events clearly establishes an extrathoracic source of the pulmonary lesions and suggests that at first there was sporadic scattered parenchymal seeding which showed regression in situ, and later an overwhelming generalized hematogenous dissemination (Figs. 1 and 2).

The cardiac silhouette revealed progressive changes consistent with the electrocardiographic patterns of right heart strain and pulmonary hypertension—but did not seem proportional to the degree of parenchymal involvement. Other x-ray studies were fruitless.

To summarize, there is a preponderance of evidence that we are dealing with neither a degenerative nor an infectious process. The metabolic disturbance is overwhelming, and, while its most conspicuous involvement is in the thorax, the very nature of the lung and heart lesions suggests an extrathoracic source of origin. The renal and hepatic impairment appears nonspectacular. The gynecologic history in the presence of normal pelvic findings and in the absence of endocrine abnormality is disturbing. One could, of course, offer multiple diagnoses to cover the situation—but single possibilities create a much more tantalizing challenge. We have excluded the degenerative processes and infections—I hope. Of the metabolic group, one could entertain vascular disorders of systemic nature and the ever elusive collagen group of diseases, but one must only look at the chest films to be impressed

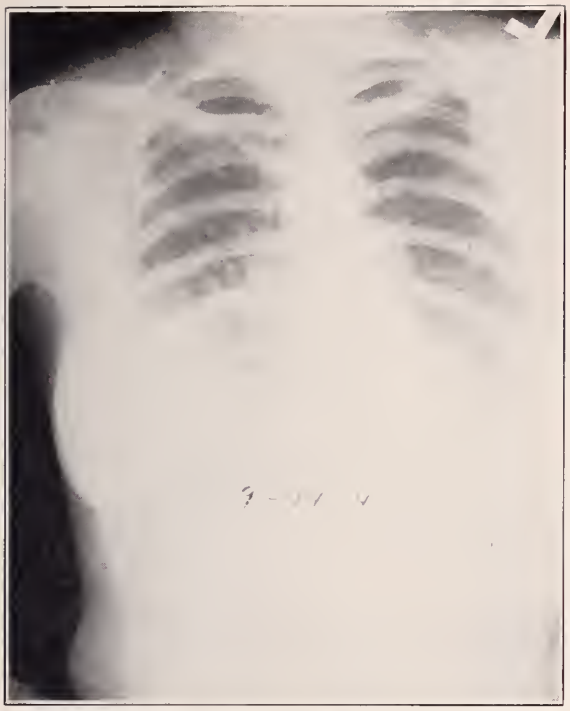


Fig. 1.—Dense parenchymal globose mass in right base with generalized vascular distribution of a fine granular pattern throughout the lung fields. Electrocardiogram was normal.

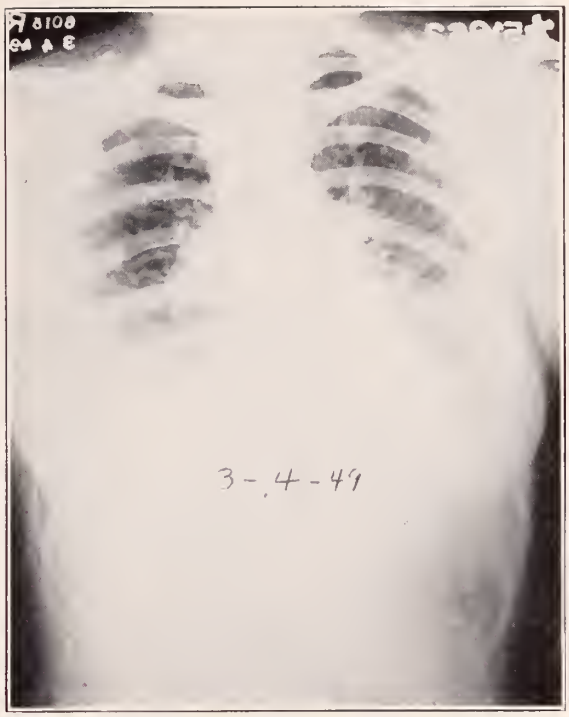


Fig. 2.—Clearing of dense mass in right base and right upper lung fields. Increase in size of left hilus with nodular parenchymal lesions of varying size and density throughout left lung. Electrocardiograms revealed right heart strain with incomplete right bundle branch block.

with the malignancy of the process. Multiple biopsy studies with negative findings support this exclusion. Furthermore, we have postulated that the pulmonary involvement was extrathoracic in origin. Here, I feel, lies the real key to the diagnosis. Vascular disorders, such as the arteritis group and collagen diseases, would affect the lungs intrinsically by means of their vascular bed—but here we have established, and correctly I hope, that the most clinically obvious pathologic changes are extrinsic in origin.

I recall a case of chorioepithelioma of the lung. The feature that impressed me most was the waning and waxing of the parenchymal lesions. This is a feature of this case. The gynecologic history which has not been explained has plagued me and may find ready solution in this diagnosis. I realize that this is a rarity. At least this diagnosis can explain the gynecologic history, the lung findings, and the heart changes secondary thereto, the suppression of hepatic and renal functions and the rapidly progressive fulminating clinical course. It can also explain the sterility of the bacteriologic and tissue studies which were carried out. If I must make a diagnosis, I'll choose that of chorioepithelioma of the uterus with invasion of the lungs and viscera.

Dr. J. M. Lubitz (Pathologist): The body was that of a moderately obese, 30 year old female. There was no external edema. Within the abdominal cavity there was 1,000 cc. of amber-colored fluid. The uterus and adnexa were not abnormal. The right lung was adherent on all aspects, and the left lung over the lower portion to the thoracic wall. The right middle and lower lobes were replaced by a dense, scarred mass, measuring 8 by 5 cm., representing an organizing infarction. Most recent infarctions, measuring up to 3 cm., were also found in the right lower lobe and in the left upper and lower lobes. In the left upper lobe there was also an older infarction measuring 3.5 cm. The smaller blood vessels throughout the lung were prominent, contained firm, pinkish tan thrombi, and formed the centers of small nodules. The pericardial sac contained 500 cc. of a clear fluid, although the heart itself exhibited brown atrophy, weighing but 200 Gm. The right heart was dilated and hypertrophied.

Fig. 3.—Gross lung: The tumor thrombus completely obstructs the main pulmonary artery.

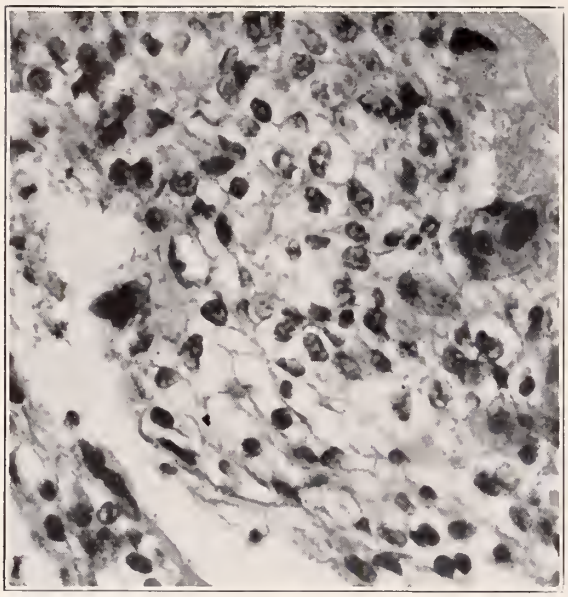


Fig. 4.—Photomicrograph of tumor thrombus of lung, high power; the syncytial and giant cells are characteristic for chorioepithelioma.

Beginning in the conus and extending into the branches of the pulmonary artery on both sides there was a soft, finely granular, brownish red thrombus, which completely occluded the lumen of the vessel (fig. 3). The abdominal viscera and kidneys showed severe, passive congestion. The uterus and ovaries were normal in all aspects. Microscopically, the thrombosis in the pulmonary vessels was a mixture of chorioepithelioma (fig. 4) and thrombus confined entirely to the lumen of the vessels with no extension into the lung parenchyma. The small branches showed arteritis secondary to the tumor thrombus (fig. 5). Multiple sections through the uterus showed atrophic endometrium, but no evidence of tumor.

The history gives us the clue that the origin of the chorioepithelioma was in the placenta subsequent to the abortion two years prior to death. Although no material was available for study of the placental tissue, it is very probable that part of it was undergoing hydatid degeneration. In retrospect, the irregular menses may have actually been bleeding from the uterine tumor. Reversion of the uterus to normal size and failure of bleeding to become more conspicuous indicate that the original uterine tumor had regressed. Chorioepithelioma notoriously metastasizes to the lungs, in this case being confined entirely to the pulmonary arteries. The various ages of the pulmonary infarcts attest to the repeated infarctions due to growth of the tumor within the lung. The dyspnea, chest pain, pleuritis, and bloody sputum, as well as failure to respond to antibiotics, are clinical expressions of these infarctions. The sudden death was characteristic for complete occlusion of the main pulmonary artery.

Anatomic Diagnosis.—The anatomic diagnosis is (1) metastatic chorioepithelioma to pulmonary artery and branches; (2) multiple pulmonary infarctions; and (3) hypertrophy of right heart.

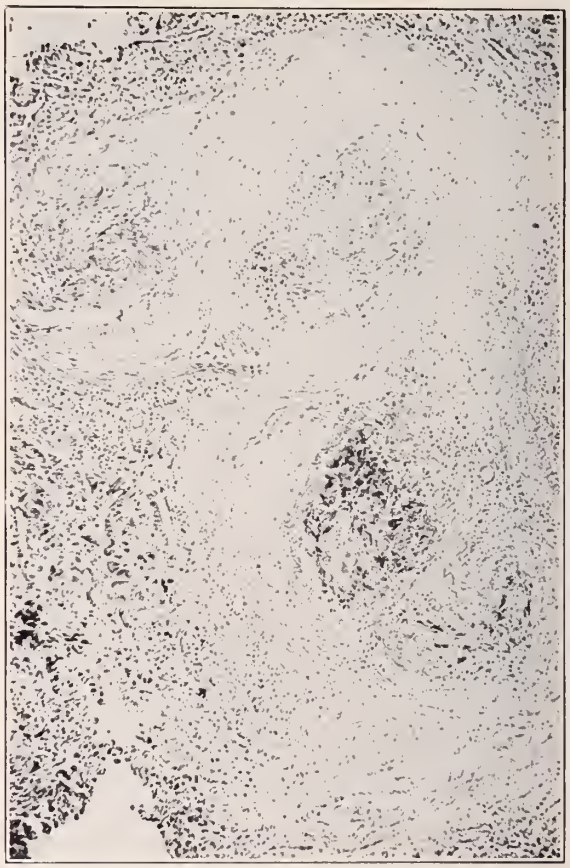


Fig. 5.—Photomicrograph of lung, low power: tumor thrombi are present within the pulmonary artery branches. The vessels are thickened. The surrounding lung tissue is fribotic and atelectatic.

Dr. D. J. Werner (Gynecologist): Chorioepithelioma is an exceedingly rare disease. When one can find no evidence of the primary uterine growth, as in this case being presented, it is more unusual.

Novak and Koff (*American Journal of Obstetrics and Gynecology*, August 1930) reported on a similar case of chorioepithelioma with extensive metastases, where the primary uterine growth disappeared. They suggest three possible explanations:

1. That the uterus is not actually the point of origin and the distant growths are really of teratomatous nature.

2. That chorioepitheliomatous growths in such distant organs as the lungs may arise from malignant degeneration of trophoblastic emboli even when the placenta itself snows no malignancy. This view is difficult to establish because of the difficulty of excluding small localized areas of chorioepithelioma in the placenta, for they can easily be overlooked or missed even on careful examination. Trophoblastic pulmonary emboli are reported to occur in at least 80 per cent of women during normal pregnancy. This has been called physiologic metastasis. Hence their presence in the lungs is not evidence of malignancy.

3. That the original primary lesion was removed by curettage. The lesion usually penetrates deeply into the uterine wall and is impossible to remove by a curette. However, in the very exceptional case, I suppose it might be possible to remove the localized tumor by curette so there would be no further evidence of disease in the uterus.

From a clinical standpoint, there are few cases in which previous pregnancy can be excluded, and in most of them a history of pregnancy has been present. In the case presented today, there was a history of a previous abortion; that is, a possible hydatidiform mole being expelled about nine months previous to the original chest complaint. Since no evidence of pregnancy or tumor could be found in the uterus at the time of autopsy, but extensive metastatic lesions were present, one must assume that the primary uterine lesion had disappeared, or that it was so small that it was not found on sectioning of the uterus.

AMERICAN MEDICAL ASSOCIATION SETS DATE FOR CLINICAL SESSION

The fourth clinical session of the American Medical Association, designed primarily for the general practitioner, will be held in Cleveland, December 5–8.

The scientific sessions and the scientific and technical exhibits will be presented in the Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held in the Statler Hotel.

Outstanding clinical teachers with recognized ability as speakers will headline the scientific demonstrations. Actual cases will be presented and discussed. Diagnoses, treatment, and preventive measures as they fit into daily practice will receive the greatest attention. Each clinical session will be limited to an attendance of 100 physicians. These small groups will make it possible for the general practitioner to enter actively into the discussion and to inquire about his own cases. Leading men in each of the fields under discussion will be available to help with the problems presented.

In obstetrics, difficult cases of interest will be featured. Especially stressed will be the general subjects of breach deliveries, induction of labor, indications for cesarean section, obstetric analgesia and anesthesia, and hemorrhages.

Clinical discussions featuring actual pediatrics patients have been programmed. The care of premature infants, acute diarrhea in children, rheumatic fever, preventive medical measures and psychiatric care for small children are among the interesting topics scheduled.

Because of the unusual interest displayed last year in the section devoted to management of heart cases, there will be a similar session this year. It will include discussions on hypertension, recent advances in drug therapy, including ACTH as it applies to heart disease, acute arterial occlusion and cardiac arrhythmias. Of special interest will be discussions on Parkinsonism, the use of the electro-encephalograph, electric shock therapy and psychotherapy.

With more cases of fluid balance appearing because of the larger number of geriatric patients, there will be discussions on fluid replacement in shock, renal repairment, dehydration, and other topics. Of unusual interest will be the new studies and clinical histories involving traumatic surgery. This will include material on reconstructive surgery, emergency analgesia, and emergency surgical measures.

Taken up in detail will be the management of postoperative or inoperable cancer patients. The use of analgesics and the effects of hormone and radiologic treatment will be discussed.

An excellent program has been arranged covering diabetes. This will includes diagnosis, vascular complications, special consideration in pregnancy and surgery, and dietary problems.

Very timely will be the panel discussions and demonstrations on the diagnosis of poliomyelitis, the treatment of respiratory failure and the management of paralytic cases. There will be demonstrations of physical therapy and rehabilitation measures for poliomyelitis cases.

Papers covering practical problems in dermatology and syphilology will be presented. Deep fungous infections and industrial, allergic and contact dermatoses will be demonstrated and discussed. Emphasis will be put on the newest developments in syphilology.

New developments and refinements of older technics will feature the discussions on anesthesiology. Spinal anesthesia, management of the surgical case, intravenous administration and other practical problems will be reviewed.

Once again color television will take its place on the program. A schedule of surgery, clinical treatment and examination will be telecast from the Western Reserve School of Medicine to the auditorium. It will be sponsored by Smith, Kline and French Laboratories.

The annual General Practitioner Award has come to be regarded as one of medicine's highest honors and a definite step toward increasing the recognition of the family doctor. This year's selection will be made at the Cleveland meeting.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

A. R. ZINTEK

Doctor Zintek, a 1934 graduate of the Marquette University School of Medicine, interned at Milwaukee County Hospital and did three years of graduate work in epidemiology at the University of Michigan to earn the degree of D.P.H. in 1947. From 1945 to 1947 he was a resident lecturer in epidemiology and a research assistant in poliomyelitis at the University of Michigan. He joined the Wisconsin State Board of Health in July 1947 as director of the Bureau of Preventable Diseases.

Treatment of Communicable Diseases in General Hospitals

The communicable disease hospital, a building devoted to the exclusive care of persons with a contagious disease, is rapidly disappearing from the American scene. The marked seasonal fluctuation of epidemic disease does not permit efficient operation of an institution and staff of sufficient magnitude to take care of all requests during an epidemic period with few or no cases during interepidemic periods. The need for a contagious disease hospital has been diminished by the marked decrease of typhoid fever, diphtheria, and smallpox. The biologic change which has occurred in the virulence of the streptococcus plus improvements in specific chemotherapeutic and antibiotic therapy has, to a large extent, permitted management of these cases in the home. Not infrequently, however, it is necessary for a general hospital to care for patients with communicable diseases in the same general area as noninfectious individuals.

Actually all hospitals handle such patients whether they admit them as such or not, because in patients already under care for other reasons there not infrequently develop communicable diseases to which they have been exposed before or after admission. Moreover, every hospital unwittingly admits individuals who are a menace, some because they are carriers of respiratory or enteric pathogens, others because they have undiagnosed open tuberculosis.

Because of these contingencies adequate medical aseptic technic should be practiced on all services of every hospital at all times. Routine procedures followed in patient care, the hygienic habits of professional personnel, food handling, the disinfection of utensils and equipment, the efficiency of the laundry, the disposition of excreta and involuntary wastes, and the attitude maintained by responsible members of the medical and nursing staff will determine to a large extent the number of communicable disease "accidents" and "mysteries" which occur in the hospital. Once adequate aseptic technics and facilities have been established in the general hospital, it follows that such hospital can safely assume the care of essentially all contagion by the intelligent application of such practices. Only occasionally, as in the case of highly infectious disease such as smallpox, chicken pox, and measles, are additional measures necessary if such patients are to be cared for in the proximity of susceptibles. Actually, patients with uncomplicated measles and chicken pox seldom need hospitalization, and the average patient with smallpox should be cared for under quarantine at home.

The application of recent developments along therapeutic and prophylactic lines such as sulfanomides and antibiotics to shorten the period of communicability, and ultraviolet rays, germicidal vapors, air filters and oil treatment of floors and bedding to reduce air-borne infection further lessen the potential dangers of caring for patients with communicable disease in the general hospitals.

Unless the patient is ill enough to require the service of special duty nurses, it is not considered necessary to employ them for patients with communicable disease in the general hospital. It is the need of the patient and not the danger of cross infection that is the determining factor in the use of special nurses. A patient with poliomyelitis can ordinarily be cared for by the general duty nurse. However, a patient in a respirator would require a special duty nurse because of his need for constant supervision.

All hospital personnel responsible for patient care should routinely be given immunization against smallpox, typhoid, and paratyphoid fever, those with positive Schick reactions should receive diphtheria toxoid, and negative tuberculin reactors should be given BCG vaccine.

Although it is not economical for the general hospital to hold space vacant for the potential admission or transfer of patients with communicable diseases, it is usually possible to designate in advance private rooms which are well situated and well equipped for the purpose and which can be made available in time of actual need. Individual rooms for all patients with respiratory diseases are recommended. In an emergency situation these patients may be cared for in open wards or semi-private rooms if permanent floor to ceiling cubicles are provided. Although there is a wide difference of opinion as to the value of masks, it is believed that masks properly constructed and properly used may offer an additional barrier to the spread of air-borne disease.

—ARTHUR R. ZINTEK, M. D., *Director, Section on Preventable Diseases.*

Dr. Henry Herbert Christofferson, installed as President of the State Medical Society at its 1950 Annual Meeting, has been a leader in civic and medical work in Colby since 1910. He was born at Waupaca on March 27, 1875, and received his medical degree from St. Louis University School of Medicine in 1902. That year he entered practice in Loyal, moving to Colby eight years later. In that community he built the Colby Clinic and served as physician for the Clark County Hospital from the time of its establishment in 1922.

An active member of the State Medical Society, the doctor was Councilor for the Ninth District from 1939 to 1950. He offered the resolution creating the committee which later recommended approval of the Wisconsin Plan, and served as chairman of the Wisconsin Plan Committee from the time of its inception in 1945 until this year. For many years he was chairman of the Committee on Mental Hygiene, Institutional Care, Public Welfare, and State Departments. In 1938 he was a member of the Special Committee to Study the Distribution of Health Services and Sickness Care. Having formerly served as president, the doctor is now a member of the State Board of Medical Examiners.

The community of Colby paid tribute to Doctor and Mrs. Christofferson on July 26, 1949, the occasion of their fiftieth wedding anniversary.

The Medical Journal Was Born

By ARTHUR J. PATEK, A. B., M. D.
Milwaukee

As the October issue of The Journal was going to press, we were notified of the death of Doctor Patek on October 12. This article will serve as a valued record of the contribution which he made to the State Medical Society and, in particular, to The Wisconsin Medical Journal.

A. J. PATEK

A native of Milwaukee, Doctor Patek received his M. D. degree from the University of Pennsylvania School of Medicine in 1892. He served a two year internship and residency at the Lankenau Hospital, Philadelphia, followed by graduate studies in Europe. A past-president of the State Medical Society, he was presented the Council Award of the Society in 1935. He practiced in Milwaukee from 1896 until his death.

WHILE recently recounting some of the events in Wisconsin's early medical history at the turn of the century—events in which both of us played a minor part—it occurred to Dr. Otto H. Foerster and me that the incidents leading to the founding of *The Wisconsin Medical Journal* might prove of interest to the physicians of our state. Because this birth took place at a time when quite a radical departure in the type of American medical journalism was in the making, there may be added reason for satisfying some curiosity covering that period.

Let us go back about 50 years—say to about 1900. Medical ethics had not yet reached a very high level. It was a period when fakery was rampant and tolerated; when medical practices—later taboo—were commented upon as amoral but accepted as necessary evils; clever lawyers thwarted efforts to control medical malefactors; medical journalism was on the loose; so-called "original articles," giving details of diseases treated or benefited by nostrums controlled by prominent national manufacturing houses, were extolled beyond their value in both state and national medical journals; prominence was given quacks and quack remedies in the daily press. It is interesting to note that at about this period, when the advertising columns of some of our national lay periodicals and newspapers were heavy with medical quackery of every type, two prominent national publications—the *Ladies Home Journal* and the *New York Times*—took the lead in a policy of refusing all medical advertisements.

It may be argued that the previous paragraph is too damning to be taken at its face value and that it distorts the medical conscience of that period. In answer to this it is only fair to state that the device of proprietary appeal to the medical public was not then considered essentially unethical, because the practice was common to many of our state medical journals and to some of our national medical periodicals as well.

Medical education was in many respects rather haphazard, and there were rumblings of revolt that bore fruit following the painstaking investigation and grading of medical schools launched by the Flexner Committee. But diploma mills still flourished, and it may seem incredible to the physician of today to be told that these shortcuts to a license to practice medicine not only existed at the time but were legalized by legislative enactment. Wisconsin was only one of many states in which such free-for-all diploma grants existed. I well recall the Milwaukee Eclectic Medical College, an incorporated institution, legally empowered to teach medicine and grant a medical degree, run by notorious quacks, one of whom, fortunately, spent his later years in Waupun and after that in a Canadian prison, not by reason of quackery but because of a criminal conviction as a notorious abortionist.

Another interesting item of that period recalls the plight of a group of shady practitioners who felt themselves hamstrung by restrictive regulations. Believing that in union there is strength, they organized the "Wisconsin Medical Union of Physicians and Surgeons," incorporated for the purpose of protecting the members in their "natural and legal rights," and from "oppressive and unjust laws" and to secure enactment of laws which should be "liberal and just." It is apparent that the incorporators felt the chastening effect of the state's restrictive medical laws, and, so far as we know, this society had a very short-lived existence. The preceding are but a few of the high lights fairly descriptive of medical practices that cast a severe reflection upon acceptable standards of decency in a profession that aimed at following a high ethical code.

About this period (soon after 1900) there was being published in Milwaukee a monthly medical journal, edited by a local physician, supported and largely directed by a well known national pharmaceutical concern. This magazine extolled the virtues of its products not only in the advertising columns but in the reading pages as well. The so-called "original articles" gave details of diseases that were

treated or benefited by nostrums manufactured by the controlling proprietors. Due credit must be given the *California State Medical Journal* as foremost in its editorials excoriating other state and national medical journals for incorporating in their reading columns articles submitted by interested pharmaceutical houses. The *Milwaukee Medical Journal* (I believe that was its title) was no better and no worse than many other publications of its day, but it did not adequately represent Wisconsin medicine, and its amoral attitude was repugnant to the higher standards that prevailed among a large group of local and state practitioners. A number of these physicians, some old in practice, some young, determined upon the establishment of a Wisconsin publication that owed allegiance to no commercial house and that should properly represent the Wisconsin medical profession—published by and for it. A further aim was to gather the support of the various county medical societies by giving them an outlet for their proceedings, and thus, by their combined efforts, to add their strength in support of the state organization.

Presumably, because I had shown considerable activity in local and state medical circles and had also to my credit quite a number of contributions to medical literature, I was requested to assume the editorship of a new journal that should reflect the ideals of the Wisconsin profession. This was a flattering approach but also a formidable assignment. With many misgivings, but with the encouragement of medical confreres, I accepted the task, carrying the editorial management eight years. Drs. Otto H. Foerster and A. W. Myers soon joined me as associate editors, thus sharing many of the intricacies of editorial management. We were fortunate in requisitioning the services of Dr. Hoyt E. Dearholt, who assumed the business management of the publication in its earlier years, thus relieving us of a burdensome responsibility.

The early numbers contained original articles contributed by medical friends from near and far, among the latter being Doctors Deaver, Hare, Edsall, and Musser of Philadephia; Capps, Senn, Abt, Hektoen, Herrick, and Patrick of Chicago; Hamann of Cleveland—all names prominent in their day. In addition we served all the trimmings common to most state journals of that period: we received interesting correspondence from medical friends abroad; published the proceedings of various American medical societies (Dr. Robert Washburn acted as our Johns Hopkins correspondent); abstracted medical literature; book reviews were added; local and state society proceedings, and the doings of other medical groups, long since defunct, were recorded; dissertations on medicolegal questions were contributed by Mr. Edwin S. Mack, a distinguished and brilliant member of the bar; in short, the Journal's scope was ambitious and its conduct gave satisfaction to its sponsors. Its editorials embraced matters of local and general interest, and we did not hesitate to use the editorial prerogative of criticism where such was deemed called for. There was, from the very beginning, a determination to allow no inducement of a manufacturer to seduce the editorial staff into permitting subsidized articles to mingle with professional contribution, an ideal scrupulously adhered to.

In furtherance of this standpoint we may quote and point with some pride to two brief paragraphs taken from an early editorial. They read: "The Wisconsin Medical Journal is desirous of obtaining all the legitimate advertisements possible, but will go to its grave sooner than stultify its pages with the advertisements of nostrums that can only be termed fakish humbugs." And again: "We trust the Journal will never be so hard pressed for cash as to find itself reduced to the necessity of selling its editorial and other reading columns. Commercialism is the ruination of honest thinking and of free speech, and such an invasion is so foreign to the principles of those in charge of this publication that our readers may feel secure that their rights will at all times be upheld".

Being novices in the publishing field, our earliest difficulties were those of determining the size, form, type, spacing of articles, and a thousand other mechanical details, not to mention the correction of loosely worded contributions and the laborious reading and correction of proof. Parenthetically, be it emphasized that all these journalistic activities of the editors had to be reconciled with the primary task of carrying on medical practice.

Far from being financial wizards, we soon found ourselves floundering in ever mounting indebtedness, owing to a limited circulation and our rigid ethical standards as to the type of acceptable advertisements. With the generous assistance of a number of medical friends who supported our efforts, the *Journal* continued its monthly publication about one year, after which time—to our great relief—ownership was assumed by the State Medical Society. Thus the *Journal* became the official publication of that Society, the then acting editorial and business directives continuing to function as before.

Dr. Charles S. Sheldon of Madison, secretary of the State Medical Society, assumed the task of recording that Society's proceedings, and the secretaries of various county societies were requisitioned to register doings of local interest. Among the latter was Dr. Rock Sleyster, then secretary of the Calumet County Medical Society. Under the nom-de-plume of "Saint Boostheimer" he contributed breezy accounts of his society's proceedings. This was Doctor Sleyster's introduction to organized medicine—a career that carried him not only to the presidency of the State Medical Society, but to the presidency of the American Medical Association as well.

Eight years of editorial management was a congenial undertaking and made possible many lasting and wonderful friendships. It is this thought that carries with it, in reminiscence, the memory of an interesting assignment of almost half a century ago, a thought dimmed by the fact that the writer of this chronicle and his close friend and associate, Dr. Otto H. Foerster, are the sole survivors of that early career in editorial adventure.

Suggestions For Physicians Entering Service

Your Professional Practice

1. **Notify your Patients**
   Notify your patients of your impending departure either by printed announcements, letter, or word of mouth. If you are planning to make arrangements for a colleague to carry on your practice, advise your patients accordingly.

2. **Locum Tenens Agreement**
   Have your attorney draft a written agreement with the physician you designate to carry on your practice, covering contingencies likely to arise and clearly defining the terms of the arrangement.

3. **Case Histories**
   See that your case histories and other patient records are in good order and readily available to your successor.

4. **Accounts Receivable**
   The collection of your accounts receivable should be undertaken. Turn over the more difficult accounts *which are at least two years old* to your attorney and discuss the leniency to be extended on the other accounts with your successor physician and your office secretary. Friction and misunderstanding with your patients are thus avoided in many cases.

5. **Accounts Payable**
   Make arrangements with your creditors, if any, for the payment of your outstanding obligations. The Soldiers and Sailors Civil Relief Act provides you with protection against the entering of judgments against you during your period of service. Your attorney can advise you more fully on that score.

6. **Office Equipment**
   If the arrangement with your substitute does not contemplate a disposition of your office equipment, make adequate plans for its storage, lease, or sale. Your county or state society may be of assistance in locating a physician in need of your equipment.

7. **Disposal of Narcotics**
   Notify the Collector of Internal Revenue, giving him your narcotics registration number, and surrender your supply of narcotics to the nearest Bureau of Narcotics office. Unopened supplies may be returned to the seller or sold to another registered physician if the transaction is recorded on official forms.

8. **Office Lease**
   Your landlord will be cooperative as to the termination or alteration of your office lease. The Soldiers and Sailors Civil Relief Act saves you from further liability after your departure *if you have given proper notice.*

9. **Job Security**
   If you are practicing under a partnership arrangement, your attorney can assist you in amending your agreement so as to make adequate provision for your return to practice. If you are employed, the Soldiers and Sailors Civil Relief Act may assure you job security. See your attorney for its application to your particular situation. Contact the hospitals on whose staffs you serve as to whether your position will be open to you upon your return.

10. **Medical Societies**
    Send the State Medical Society your military address and keep your Society informed of any changes. You will continue to receive *The Wisconsin Medical Journal,* and your annual dues will be remitted for the unexpired portion of the year, for the balance of your term of service.

11. **Medical Literature**
    Suspend or arrange for the forwarding of your professional journals, services, and texts.

Your Insurance Program

1. **Malpractice Insurance**
   Retain your malpractice insurance while in service. Servicemen are entitled to the same civil rights of action between one another with respect to suits for malpractice or negligence as they would have in civil life.

2. **National Service Life Insurance**
   You will have the opportunity to subscribe for a maximum of $10,000 of National Service Life Insurance without a physical examination and at a comparatively low premium load. The insurance officer at your post, camp, or station will advise you of the settlement options available.

3. **Your Life Insurance Program**
   You should check with your attorney and insurance counselor to make certain that your designation of the beneficiaries and settlement options are current and as you want them. Make arrangements for the payment of premiums during your absence. The Soldiers and Sailors Civil Relief Act guarantees the payment of premiums on your life insurance to a limited extent. Your attorney will advise you more fully on that point.

4. **Your Casualty Insurance Program**
   A. Health and Accident, Surgical, and Hospital Insurance.
      Cancel where desirable and request both a pro rata return of premium and right of resumption when you return. If your family is to be covered, arrange for reduced premiums and payments.

B. Automobile Insurance.

Transfer your liability and other automobile insurance to your wife or whoever will be using your car. If your car will not be used for business purposes during your absence, you will probably be entitled to a reduction in premium.

C. Property Insurance.

Assure yourself that fire, liability, and other insurance on your real estate, as well as the insurance covering the loss or destruction of your personal property, is maintained in adequate amounts.

Your Personal Affairs

1. **Inventory Your Assets**

Prepare a complete inventory of everything you own and where it may be found. Leave copies with your attorney, your wife, and in your safety deposit box.

2. **Bank Accounts**

It may be advisable to consolidate your bank accounts and to place them in joint tenancy with your wife or parents. Arrangements should be made with the bank so that you will be provided with periodic statements of your account and for the receipt and crediting of allotments from your service pay.

3. **Will**

Your will should be critically appraised by your attorney and appropriate changes made to bring it up to date.

4. **Power of Attorney**

There is also the question of executing a power of attorney to your wife, attorney, or trusted friend to transact necessary business for you in your absence.

5. **Safety Deposit Box**

Your important documents and securities should be assembled and kept securely. A safety deposit box may be the answer to that problem.

6. **Your Address**

File a change of address card with your local post office with instructions to have your mail forwarded to some responsible person. In addition, it is important to keep at least two persons advised as to where you may be reached at all times.

7. **Taxes**

Compute your income for the fraction of the year prior to your departure and estimate your property tax for that year. While Soldiers and Sailors Civil Relief Act postpones payment until you return from service, the computation had best be made now for obvious reasons, and paid if possible.

8. **Lodge Memberships and Clubs**

Notify and arrange for suspension of dues according to whatever rules govern.

9. **Credit Resources**

Arrange for family to obtain credit or loans in emergencies.

10. **Mortgages or Land Contracts**

Arrange with lender for deferment of principal payments if necessary. Your attorney will advise you of the protection afforded you under the provisions of the Soldiers and Sailors Civil Relief Act.

WISCONSIN TRUDEAU SOCIETY SCHEDULES DECEMBER MEETING

The Wisconsin Trudeau Society will meet at the Veterans Administration Hospital, Waukesha, on December 2. All physicians interested in diseases of the chest are invited to attend. Speakers and subjects for the meeting are as follows:

9:30– 9:45 "Pneumoperitoneum"—Elvira C. Seno, M.D., Veterans Administration Hospital, Waukesha
9:45–10:00 "Pneumothorax"—Gustaf A. Hedberg, M.D., superintendent, Nopeming Sanatorium, Nopeming, Minn.
10:00–10:15 "Cavity Drainage"—Paul F. Hausmann, M.D., department of surgery, Muirdale Sanatorium, Wauwatosa
10:15–10:30 "Paraffin Pack; Lucite Ball Filling"—John D. Steele, M.D., department of surgery, Muirdale Sanatorium, Wauwatosa
10:30–10 45 "Phrenic Nerve Interruption"—Christopher J. Stringer, M.D., superintendent and medical director, Ingham County Sanatorium, Lansing, Mich.
10:45–11:00 "Bilateral Thoracoplasty"—E. P. K. Fenger, M.D., Glen Lake Sanatorium, Oak Terrace, Minn.
11:00–11:15 "Isolated Pulmonary Lesions"—Joseph W. Gale, M.D., professor of surgery, University of Wisconsin Medical School, Madison
11:15–12:00 Discussion
12:00– 1:00 Luncheon
1:00– 1:15 "Spontaneous Pneumothorax"—Helen A. Dickie, M.D., department of medicine, Wisconsin General Hospital, Madison
1:15– 1:30 "Decortication"—Anthony R. Curreri, M.D., department of surgery, Wisconsin General Hospital, Madison
1:30– 2:00 "Wrapping of Aortic Aneurysms"—Herbert E. Sloan, Jr., M.D., department of surgery, University of Michigan General Hospital, Ann Arbor, Mich.
2:00– 2:30 "Streptomycin and Pulmonary Resection"—William B. Tucker, M.D., Veterans Administration Hospital, Minneapolis, Minn.
2:30– 2:45 "Retention of Lipiodol in Bronchiectasis"—Dann B. Claudon, M.D., department of pathology, Columbia Hospital, Milwaukee

News Items and Personals

Dr. George Mohler Begins Practice at Oconto

Dr. George Mohler, formerly of Mondovi, opened a medical office in Oconto early in September. A graduate of Columbia University College of Physicians and Surgeons, the doctor served as a resident physician at Luther Hospital, Eau Claire, following his discharge from the Army Medical Corps. He has been practicing medicine at Mondovi since 1948.

Insurance Firm Names Dr. R. E. Henning Examiner

Dr. Roger E. Henning, Neenah, was recently elected supreme medical examiner of the Equitable Reserve Association by its board of trustees. Named associate medical examiner in 1949, Doctor Henning will succeed Dr. George H. Williams, who retired after thirty-two years of service. Doctor Henning, who has been in practice in Neenah since 1948, was associated with the Jackson Clinic at Madison for three years prior to his location in Neenah.

Fond du Lac Physician Addresses Rotarians

Guest speaker at the Fond du Lac Rotary Club meeting at the Hotel Retlaw on August 28 was Dr. Frederick Goetz, who left Korea in June only two weeks before fighting began. Doctor Goetz was in Seoul with the United States military advisory offices. The doctor described the differences in the Korean and American civilizations and showed color slides of Korea and the customs of that country.

Dr. W. J. Petters Joins Clinic Staff at Waupun

Dr. W. J. Petters, Waupun, on September 1 became associated with the staff of the Schrank Clinic in that city. Doctor Petters began his practice in Waupun in 1948, in association with the late *Dr. K. A. Swartz*.

Reception Held for New Statesan Medical Director

Dr. Ellison F. White, new medical director of the Wisconsin State Sanatorium, Statesan, was honored at a reception on September 3. The doctor assumed his duties on August 31, coming from the Middle River Sanatorium in Douglas County to join the staff. Members of the staff of the sanatorium attended the gathering, to which *Dr. Robert Dancey*, Waukesha, former sanatorium consultant, and *Dr. J. W. Gale*, Madison, had also been invited.

Dr. H. O. Caswell Speaks to Women's Group

Dr. H. O. Caswell, Fort Atkinson, was the principal speaker at the initial meeting of the Woman's Club of Lake Mills on September 19. The title of his address was "Fifty Years in the Practice of Medicine."

Marshfield Physician Addresses Alumnae Association

Members of the St. Joseph's Alumnae Association heard a talk by *Dr. Norman J. Helland* of the Marshfield Clinic on September 12, when they met in the auditorium of the nurses' residence. Doctor Helland, who joined the clinic staff in July, spoke on "Preoperative and Postoperative Care of Urological Cases."

Family Gathering Honors Retired Physician

A family gathering was held in Waukesha on September 3 to honor *Dr.* and Mrs. *J. A. Jackson* of Wausau. The doctor recently retired, following thirty years of practice at Mosinee. A graduate of Bennett Medical College, Chicago, the doctor practiced at Berlin and Rudolph before moving to Mosinee. He is a life member of the State Medical Society.

Portage Physician Named Head of Red Cross Unit

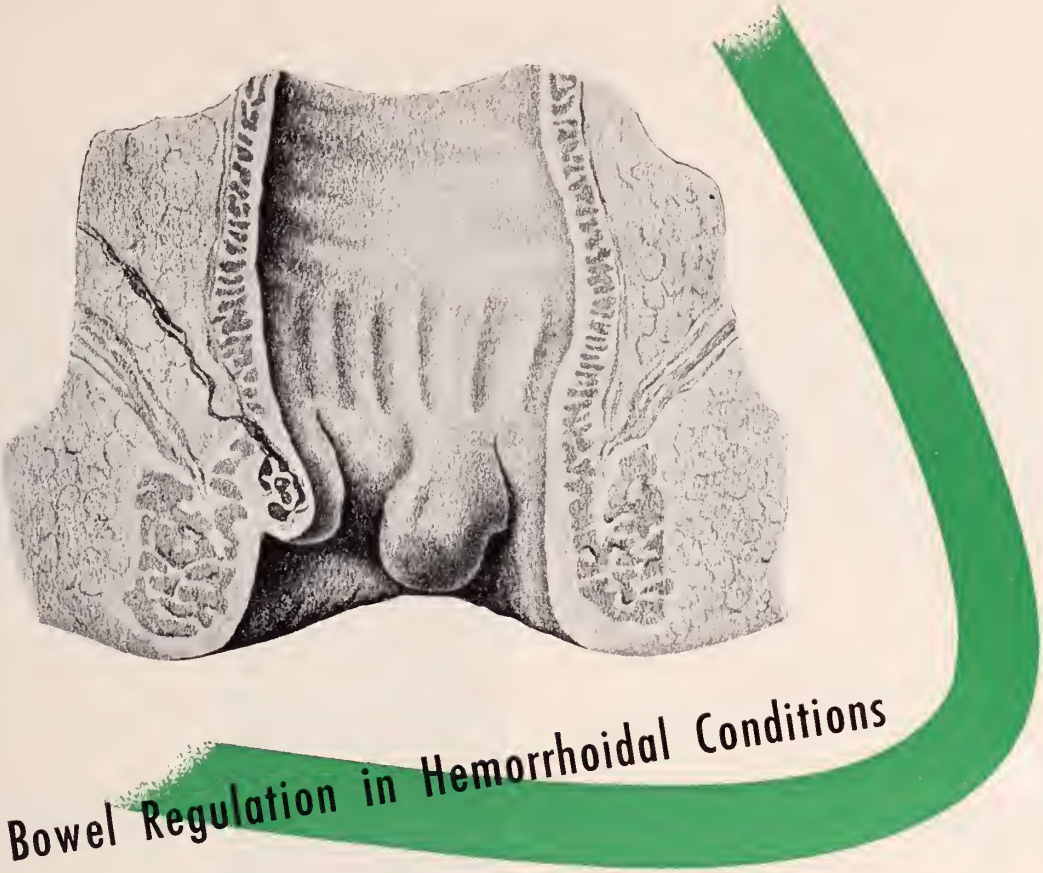
Dr. Stewart Taylor, Portage, was elected chairman of the Columbia County chapter of the American Red Cross at the annual meeting on September 12 at the county courthouse in Portage. *Dr. H. E. Gillette*, Pardeeville, was named vice-chairman.

Appleton Physician Addresses Kiwanians

Members of the Oshkosh Kiwanis Club heard a talk on heart disease by *Dr. J. B. MacLaren*, Appleton physican, at a meeting held at the Hotel Athearn on September 19. The doctor pointed out that hypertension and arteriosclerosis are two major heart diseases which bear attention and that remedies are generally found in proper exercise according to one's needs. Doctor MacLaren also spoke to the Appleton unit of the Daughters of Zion on the same subject that evening.

Society for Mental Health Names Dr. R. C. Parkin President

Dr. Robert C. Parkin, coordinator of graduate medical education at the University of Wisconsin Medical School, was named president of the Wisconsin Society for Mental Health at the third statewide mental health conference sponsored by the society on September 15 at the Hotel Schroeder, Milwaukee. *Dr. Carroll Osgood*, Milwaukee, was named second vice-president. The new director of the division of mental hygiene of the State Department of Public Welfare, *Dr. Leslie A. Osborn*, was the speaker at the president's dinner on Friday evening.



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Society Proceedings

Kenosha

A Chicago hematologist, Dr. Raphael Isaacs, was the guest speaker for a meeting of the Kenosha County Medical Society at the Elks Club in Kenosha on September 7. Doctor Isaacs, attending physician in hematology at Michael Reese Hospital, discussed "Recent Advances in Diagnosis and Treatment of Diseases of the Blood and Blood-Forming Organs."

Marinette—Florence

Meeting at the Riverside County Club near Menominee, Michigan, on September 20, members of the Marinette–Florence County Medical Society heard a talk by *Dr. Ovid O. Meyer* of Madison. Doctor Meyer, professor of medicine at the University of Wisconsin Medical School, spoke on "Recent Advances in Therapy."

Pierce—St. Croix

A film on the "Treatment of Anorectal Diseases" was shown by Mr. C. E. Cory of the William S. Merrell Company at a meeting of the Pierce–St. Croix County Medical Society on September 19. The meeting was held at the Glen Park Lodge in River Falls.

Racine—Kenosha—Walworth

Members of the Kenosha and Walworth county medical societies were guests of the Racine County Medical Society at the annual Tri-County medical meeting on September 13 at the Racine Country Club. The session opened in the morning with a discussion of "Cardiovascular Renal Disease and Hypertension" by Drs. R. D. Taylor and A. C. Corcoran of the department of internal medicine, Cleveland Clinic, Cleveland. Dr. Stanley Gibson, emeritus professor of pediatrics at Northwestern University Medical School and a consultant in cardiology at Children's Memorial Hospital, Chicago, spoke on "The Diagnosis of Congenital Cardiovascular Defects." "The Surgery of Congenital Cardiovascular Disease" was discussed by Dr. Willis J. Potts, associate professor of surgery at Northwestern University Medical School and surgeon-in-chief at Children's Memorial Hospital, Chicago. The scientific program was concluded with a paper on "Urological Problems in General Practice" by Dr. Frederick Schacht, associate professor of urology at the University of Illinois College of Medicine. Following a luncheon the doctors played golf, and a dinner was served at 7 o'clock. Wives of the doctors were also entertained during the day with golf and cards and attended the dinner in the evening. In addition to the scientific speakers, guests included *Dr. J. W. Truitt*, Milwaukee, president of the State Medical Society; *Dr. W. C. Stewart*, Kenosha, speaker of the House of Delegates; and *Dr. T. C. Hemmingsen*, Racine, Councilor from the Second District.

Winnebago

A movie entitled "Oxygen Therapy in Heart Disease" was shown to members of the Winnebago County Medical Society at a dinner meeting on August 31. The group met at the Hotel Athearn in Oshkosh.

American Academy of General Practice, Manitowoc Chapter

A. L. TATUM

Dr. Arthur L. Tatum, chairman of the department of pharmacology at the University of Wisconsin Medical School, spoke before a luncheon meeting of the Manitowoc County chapter of the American Academy of General Practice at Hotel Manitowoc on September 7. The doctor entitled his presentation "Confessions of the Medical Scientist." Visiting physicians at the meeting included *Drs. C. C. Gascoigne*, Kohler; *Ira Bemis*, Adell; *F. A. Leighton*, Sheboygan Falls; *J. P. Canavan* and *G. E. Forkin*, Menasha; and *Dr. H. N. Heinz*, Kohler.

Wisconsin and Upper Michigan Society of Ophthalmology and Otolaryngology

The fall meeting of the Central Wisconsin Society of Ophthalmology and Otolaryngology was held at Leatham Smith Lodge at Sturgeon Bay on September 9 and 10. *Dr. J. K. Trumbo* of Wausau was named president of the organization; *Dr. E. J. Zeiss*, Appleton, first vice-president; Dr. H. D. McEachran, Iron Mountain, Michigan, second vice-president; and *Dr. G. L. McCormick*, Marshfield, secretary-treasurer. It was voted at the business session to change the name of the organization to the Wisconsin and Upper Michigan Society of Ophthalmology and Otolaryngology, as the membership is no longer confined to the central part of Wisconsin but includes members from throughout the state and Upper Michigan.

The scientific program opened on Saturday afternoon with a discussion on "The Management of

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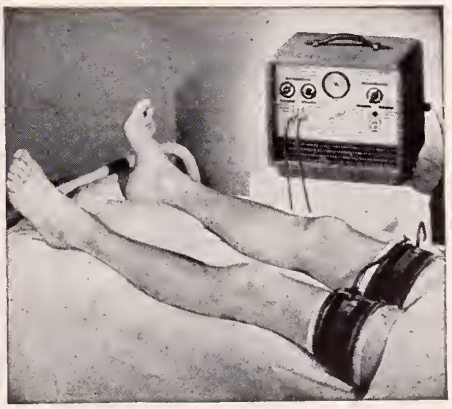

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Diseases of the Esophagus," by Dr. Paul H. Holinger of Chicago. Dr. William F. Moncreiff, also of Chicago, spoke on "The Aphakic Eye in Relation to Modern Trends in Cataract Surgery"; and the program concluded with a discussion of "Induced Neuromuscular Anomalies," by *Dr. Aubrey H. Pember* of Janesville. A social hour and dinner followed. On Sunday morning Doctor Moncreiff gave "A Review of the Surgical Treatment of Congenital Cataract: Indications, Technic, Preoperative and Postoperative Management." Doctor Holinger spoke on "Laryngeal Obstruction in Infants and Children," and Dr. W. S. Jones of Menominee, Michigan, presented a paper entiled "An Eye, Ear, Nose, and Throat Physician Takes Inventory." The business session concluded the meeting.

Wisconsin Association for Public Health

The annual meeting of the Wisconsin Association for Public Health was held at the Memorial Union at Madison on September 11. *Dr. S. E. Gavin*, Fond du Lac, president of the Wisconsin State Board of Health, opened the program with a welcoming address, and *Dr. W. D. Stovall*, president of the association, presided. Dr. David M. Cox, lecturer in applied psychology at Northwestern University, was the principal speaker. He pointed out the keys to good public relations as being superb performance by all those engaged in public health and information on what the "customer" wants. Also a guest speaker at the meeting, Mr. H. E. DePew, general manager of the Luick Dairy in Milwaukee, spoke for uniformity in health codes and a reduction of overlapping inspections.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Brodhead Doctor Attends Rural Life Convention

Dr. M. W. Stuessy, Brodhead, attended the National Country Life Convention in St. Paul on September 6 in the capacity of resource personnel for the section on rural health and safety. Doctor Stuessy is the chairman of the Committee on Rural Health of the State Medical Society.

Administrative Assistant Retires from State Board of Health

Following thirty-four years of service with the State Board of Health, Mrs. Bernice Miller recently retired from her position as administrative assistant in the section on environmental sanitation. Mrs. Miller began working for the Board of Health in 1916, spending all but four years in the department of environmental sanitation. Co-workers honored her at a dinner at the Hoffman House on August 21. Guests included *Dr. C. S. Harper*, former state health officer; *Dr. H. M. Guilford*, former director of the bureau of communicable diseases; and *Dr. C. N. Neupert*, state health officer.

Janesville Health Officer Attends Convention of Sanitarians

Dr. Fred B. Welch, city health officer at Janesville, attended the fourteenth annual convention of the National Association of Sanitarians at St. Louis, Missouri, August 22–25. The doctor was awarded an honorary certificate of membership in the national association two years ago, during a convention at Salt Lake City.

Madison Doctor Speaks to Kiwanis Club

"That Heart of Yours" was the title of a talk by *Dr. Chester M. Kurtz*, Madison, at the Appleton Kiwanis Club meeting at the Conway Hotel, August 23. Doctor Kurtz is an associate professor of medicine at the University of Wisconsin Medical School and medical director of the Kiddie Camp home for children with rheumatic fever in Madison.

Monroe Physician Addresses Industrial Group

Dr. John A. Schindler, Monroe, spoke before the International Association of Industrial Boards and Commissions at the Hotel Schroeder, Milwaukee, on September 25. The previous week he traveled to Wichita, Kansas, where he spoke at a convention of public school teachers.

Madison Physicians Open Clinic

Drs. Arvin B. Weinstein and *Jack H. Kamholz*, both of Madison, recently became associated in practice in a new clinic building on Monroe Street in that city. Doctor Weinstein, a native of Madison, received his M. D. degree from the University of

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Wisconsin Medical School in 1944, interning at Mount Sinai Hospital in Chicago. For three years he was a resident physician in internal medicine at the State of Wisconsin General Hospital and in 1948 he became an instructor in medicine and cardiology at the University of Wisconsin Medical School. He is one of the cardiac consultants to the Madison and Dane County Rheumatic Fever Program.

Doctor Kamholz was graduated from the University of Pennsylvania Medical School in 1942 and interned at the Graduate Hospital of that institution. Following three years in the Army Medical Corps, he was separated with the rank of major, then spent one year in the department of obstetrics and gynecology at the Graduate School of Medicine of the University of Pennsylvania. Three years were then spent as a resident physician in obstetrics and gynecology: one year at Sibley Memorial Hospital, Washington, D. C., and two years at the Jewish Hospital, Philadelphia.

SOCIETY PROCEEDING

Green

The Green County Medical Society held a dinner meeting at the Swiss Wheel, Monroe on September 18. *Drs. W. D. Stovall*, Brodhead, and *John Herweg*, Monroe, were received as members in the organization.

TWELFTH DISTRICT NEWS

Dr. R. S. Merrill Enters United States Navy

Dr. Robert S. Merrill, formerly of Milwaukee, entered service with the United States Navy in August. He is stationed at Oaknoll Naval Hospital, Oakland, California. The doctor received his medical degree from Washington University School of Medicine, St. Louis, in 1946, interning at Columbia Hospital, where he remained as a resident in internal medicine.

Wauwatosa City Council Names School Physicians

Drs. Glen E. McCormick and *F. N. Peterson*, Wauwatosa, were named school physicians by the city council of Wauwatosa on August 15. Doctor McCormick is a resident in pediatrics at Milwaukee Children's Hospital, and Doctor Peterson maintains a private practice in pediatrics and plastic surgery in Milwaukee.

Dr. Paul Jahn Speaks to Cudahy Women's Club

Dr. Paul Jahn, Milwaukee physician, was the guest speaker at the opening meeting of the Cudahy Woman's Club on September 11 at the Legion Hall in that city. His topic was "Is Tuberculosis Preventable?" Doctor Jahn is a clinical instructor in medicine at Marquette University School of Medicine.

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J. D. Millenbah, Citizens American Bank Building, Merrill.

Henry W. Wood, Neenah.

Gilbert R. Sandgren, Suring.

Aaron Sweed, Waukesha.

J. F. Zagaria, St. Mary's Hospital, Wausau.

Changes in Addresses

L. O. Rupe, Madison, to 116 West Dinehart Avenue, Elkhart, Indiana.

M. W. Nelson, Madison, to 600 South Bluff Street, Janesville.

Hans Hartenstein, Chicago, to Wisconsin General Hospital, Madison.

R. J. Krill, Milwaukee, to Muskego.

R. D. Johnson, Black River Falls, to 1163 Ware Court, Ypsilanti, Michigan.

C. R. Kwapy, Milwaukee, to 558 Main Street, Oconto.

H. H. Harding, Jr., Milwaukee, to 1003 Winford, Green Bay.

R. M. McCormack, Milwaukee, to School of Medicine, University of Rochester, Rochester, New York.

J. D. Lynch, Fort Benjamin Harrison, Indiana, to 203A North Eighth Street, Manitowoc.

R. L. Paver, Wauwatosa, to 1630–39th Street, San Francisco, California.

E. Z. Hornberger, Milwaukee, to 1600 Rogers Avenue, Fort Smith, Arkansas.

O. H. Dittmer, Jr., Durand, to 317 Watson Street, Ripon.

Walter Bigford, Port Edwards, to Ripon.

H. H. Alderfer, Madison, to 1119 West 4th Street, Marion, Indiana.

W. G. Smirl, Wilmington, Delaware, to 147 Wilbur Avenue, Waukesha.

L. F. Thurwachter, Wood, to 334 North 74th Street, Milwaukee.

MARRIAGE

Dr. Robert T. Cooney, De Forest, to Miss Judy Amundson, Madison, on August 26.

DEATHS

Dr. T. R. Spears, physician at Washburn for fifty-four years, died at his home in that community on September 7. He was 86 years old.

Born at Green Bush on July 29, 1864, the doctor taught school before entering medical school. He received his degree in medicine from Rush Medical College in 1889 and established his first practice in Boyd. In 1891 he moved to Washburn, where he practiced until his retirement two years ago, except for two years at the Augustana and St. Mary's hospitals in Chicago. In 1897 and 1898 he was on the city school board, and since 1935 he had served as city health officer. For more than twenty years the doctor was the local physician for the Northern Pacific Railroad and for more than fifty years he served in the same capacity for the Omaha Railway.

Survivors include his wife and a son.

Dr. Ivan G. Ellis, Madison roentgenologist, died suddenly at his home in that city on August 18. He was 50 years old.

Doctor Ellis was born in Milwaukee on October 19, 1899. He received his M. D. degree from Rush Medical College, Chicago, in 1925, and completed his internship at the Evanston General Hospital, Evanston, Ill. For two years he held a fellowship in the roentgenology department at St. Luke's Hospital, Chicago. He served as director of the x-ray department at St. Mary's Hospital, Madison, for twelve years before establishing a private practice in Madison in 1943. The doctor also served on the staffs of St. Mary's Hospital, Watertown, and Divine Savior Hospital, Portage.

A diplomate of the American Board of Radiology, Doctor Ellis was also a member of the Radiological Society of North America, the American College of Radiology, the Dane County Medical Society, State Medical Society, and American Medical Association.

He is survived by his wife, a daughter, and a son.

Dr. Andrew S. Pfeiffer, 59, Racine physician, died at his home in that city on September 18. He had practiced medicine in Racine for thirty-five years and was the founder of the Pfeiffer Clinic.

Doctor Pfeiffer was born in Kewaskum on November 6, 1890. He received his M. D. degree from the University of Illinois College of Medicine in 1915, interning at St. Mary's of Nazareth Hospital, Chicago. He practiced in Chicago for several years before locating in Racine in 1918, where he established the Pfeiffer Clinic in 1925. He was a member of the staff of St. Luke's Hospital.

The doctor held membership in the Racine County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife. A son was killed in action during World War II.

Dr. Lorne A. Campbell, 70, Clear Lake physician, died suddenly at his home on September 16. He had practiced in Clear Lake since 1908.

Doctor Campbell was born in Pakenham, Ontario, Canada, on April 9, 1880. He attended the University of Minnesota Medical School, graduating in 1904. His first practice was established at Cylon, and he located in Clear Lake in 1908.

He was a member of the Polk County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, two daughters, and two sons, both of whom are practicing physicians.

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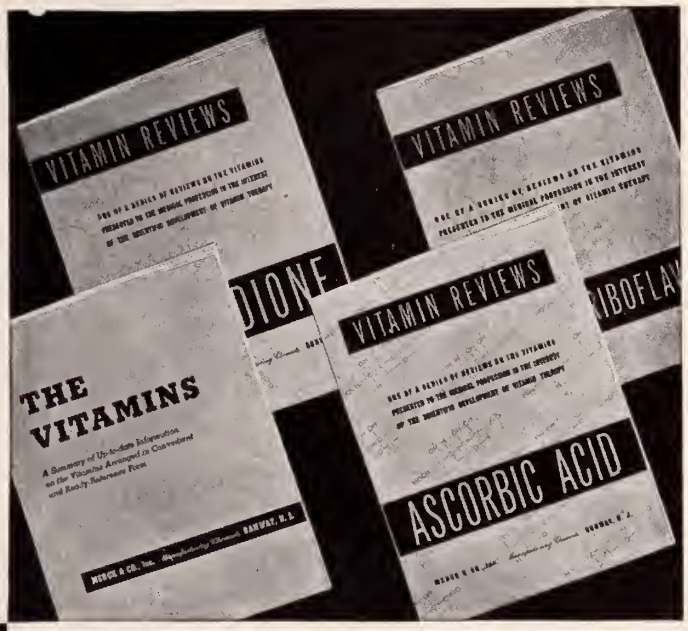

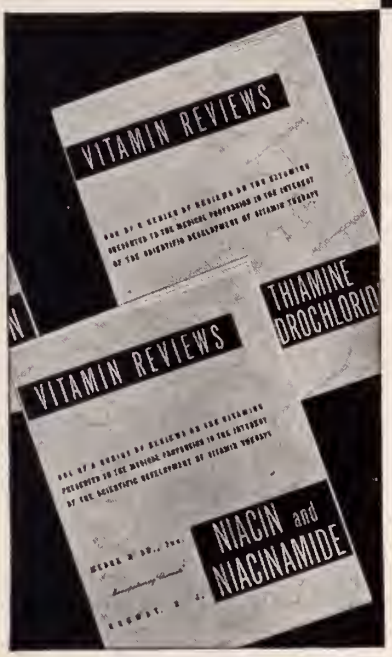

These six Merck *Vitamin Reviews* are yours for the asking while the editions last. These concise reviews contain up-to-date, authoritative facts and can be most useful for quick reference. Please address requests for copies to Merck & Co., Inc., Rahway, N. J.

Partial Index of Contents

- **Factors that produce avitaminosis.**
- **Signs and symptoms of deficiency.**
- **Daily requirements and dosages.**
- **Distribution in foods.**
- **Methods of administration.**
- **Clinical use in specific conditions.**

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Dr. Charles H. Dodge, Clinton physician for the past thirty-six years, died at a Madison hospital on September 8. He was 59 years old.

Doctor Dodge was born in Lynn township, Walworth County, on July 2, 1890. He received his medical degree from Marquette University School of Medicine in 1913, interning at Milwaukee Children's Hospital. He established his first practice at Clinton in 1914, and during World War I served with the Army Medical Corps. In 1925 he opened an office in Beloit, where he practiced for several years, also maintaining an office in Clinton. At different times he took postgraduate courses at the Université de Dijon in France, the New York Lying-In Hospital, and the Chicago Lying-In Hospital. An associate member of the staff of Beloit Municipal Hospital, he was a former member of the Clinton school board and, at the time of his death, served as health officer for Clinton township.

His wife survives.

Dr. Burton Clark, physician at Oshkosh since 1926, died suddenly at his home in that city on September 3. He was 51 years old.

A native of Oshkosh, the doctor was born on February 19, 1899. He received his medical degree from Harvard Medical School in 1923 and interned at St. Luke's Hospital, Chicago, and Peter Bent Brigham Hospital, Boston. He completed a surgical residency at Lakeside Hospital, Cleveland, before returning to Oshkosh in 1926. He was a member of the staff of Mercy Hospital in Oshkosh.

Certified by the American Board of Surgeons, the doctor was a member of the American College of Surgeons, Wisconsin Surgical Society, American Association of Railway Surgeons, Winnebago County Medical Society, State Medical Society, and American Medical Association.

Two daughters survive.

Dr. August Sauthoff, former clinical director and assistant superintendent of the Mendota State Hospital, died at a Madison hospital on September 19, following injury in an auto accident near Madison two days previously. The doctor was 74 years old.

Doctor Sauthoff was a native of Madison, born on March 24, 1876. He taught for several years before entering Rush Medical College, from which he was graduated in 1905. He did postgraduate work in psychiatry at the University of Hamburg, Germany, with the late Dr. M. K. Green, for many years superintendent at Mendota State Hospital. The two also studied at the Manhattan Hospital, New York. In 1906 he joined the staff at Mendota, where he was made clinical director in 1924. Five years later he was named assistant superintendent, holding that position until his retirement in January 1947.

He was a member of the Dane County Medical Society, the State Medical Society, and the American Medical Association.

There are no immediate survivors. His wife, who was also a physician, preceded him in death.

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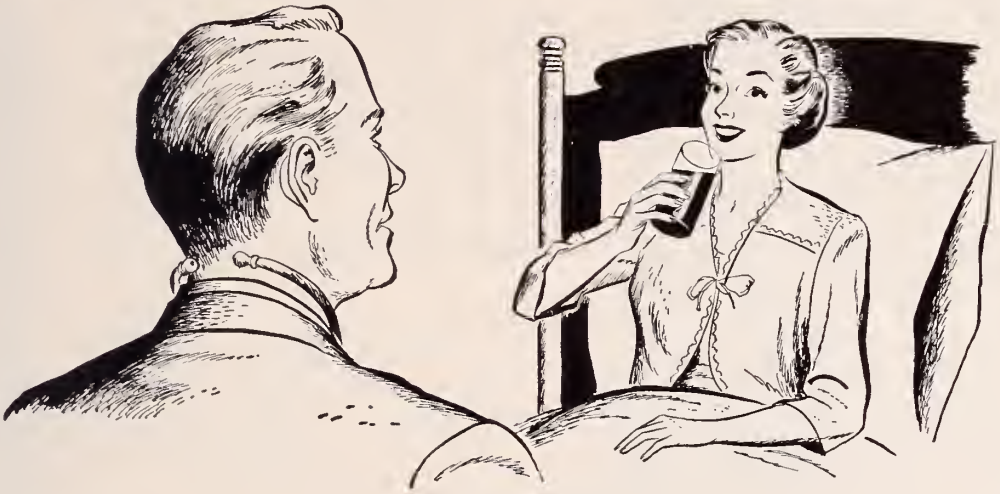

Whether the condition under treatment is an acute infection, a bowel upset, an injury or a metabolic derangement, nutrition is always a primary factor in therapy. Regardless of other indicated measures, nutritional adequacy is essential for prompt recovery.

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Fundamentals of Otolaryngology; A Textbook of Ear, Nose, and Throat Diseases. By Lawrence R. Boies, M. D., Clinical Professor of Otolaryngology, Director of Division of Otolaryngology, University of Minnesota Medical School, and Associates. Pp. 443, with 184 figures. Philadephia and London: W. B. Saunders Company, 1949. Price $6.50.

This is one of the newest and one of the best books in the field of otolaryngology.

All phases of this specially are covered, including disorders of the esophagus, and foreign bodies in the air and food passages. In addition, there are two excellent chapters on tumors of the nose and throat, and prescriptions and therapeutic procedures.

The book is not a large one, but the information presented is well organized, concise, and nicely illustrated.

I believe this would be a very valuable, up to date text for the medical student as well as the general practitioner.—M.B.

Atlas of Roentgenographic Positions. By Vinita Merrill. Volumes I and II. St. Louis, The C. V. Mosby Company, 1949. Price $30.00.

These volumes consist of a brief outline of the care and handling of the patient, aseptic technic, ethics, and other general subjects in the first chapter. The second chapter is devoted largely to a description of anatomic terminology. The remainder of the material concerns positioning for radiography of the various structures and regions of the body preceded by a brief description of the pertinent anatomy. Brief sections on such special procedures as bronchography, cerebral angiography and pneumography, angiocardiography, cholangiography, sialography, pelvimetry, and the various methods of investigating the urinary tract are included, in addition to several others.

All positions discussed are well illustrated with roentgenograms and pictures taken with the subject in proper relation to the central ray. The text is confined strictly to positioning of the patient, with technical factors excluded because of the author's feeling that these factors are too variable to be included in a work of this type. The atlas should be valuable as an easily understandable and well illustrated reference for the radiologist as well as the technician.—J.H.J.

Operative Technic in General Surgery. Edited by Warren H. Cole, M. D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago. Introduction by Frank H. Lahey, M. D., F.A.C.S. Vol. 1. New York, Appleton–Century–Crofts, Inc., 1949. Price $16.00.

This is Volume I of a two volume series on operative technic and is the work of various contributing authors. One need only to look at the list of the contributors to see that they represent progressive workers in their various fields and have contributed chapters on subjects upon which they are eminently qualified to write. As mentioned in the introduction by Dr. Frank H. Lahey: "This book has the great advantage of having the various subjects presented by men who have had experience with the particular subject about which they write." Each chapter is a separate monograph on a specific subject and includes the latest information available about the subject. The chapters are well written, and there are many good illustrations which clarify the points in the text. There is little if any overlapping between the various authors. Enough of the anatomy, physiology, and pathology are included to make it a ready reference book for the surgical resident, the part time surgeon or for the full time surgeon. Only accepted procedures in surgery are described, and obsolete methods of treatment are not included. The descriptions are orderly, clear, and well illustrated, making it easy to follow the steps in each operation. I highly recommend this volume to those doing surgery or to anyone interested in surgery. I feel that this volume is a welcome addition to my own surgical library.—K.E.L.

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Handbook of Materia Medica, Toxicology, and Pharmacology; for Students and Practitioners of Medicine. By Forrest Ramon Davison, B.A., M.Sc., Ph.D., M.B., Consultant and Toxicologist, Minneapolis, Minnesota; Formerly Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Little Rock; Medical Department, The Upjohn Company, Kalamazoo, Michigan; Assistant Professor of Pharmacology, University of Tennessee Medical School; Toxicologist to University Clinics, Memphis, Tennessee. Fourth edition. Pp. 730, with 35 illustrations, 4 in color. St. Louis, The C. V. Mosby Company, 1949. Price $8.50.

The fourth edition of this text has been substantially increased in subject matter. Thus, the former synopsis character of the book has been changed toward that of a classroom textbook. To avoid an undue increase in the size of the book the type face is extremely small. Clear, sharp printing makes reading not too great an eye strain. The general composition of the book is good.

The extremely rapid pace at which new therapeutic agents have been developed, and exact and specific facts determined for older drugs, *now practically* precludes adequate discussion of them in synopsis form. Certainly in this handbook generalities and rather vague or indefinite actions are ascribed to drugs in almost any section one chooses to examine. Critical evaluation and analysis are not presented. Certain stated facts do not agree at all with present pharmacologic concepts.—O.S.O.

Diagnosis and Treatment of Brain Tumors and Care of the Neurosurgical Patient. By Ernest Sachs, A. B., M. D., Research Associate in Physiology, Yale University, New Haven; Formerly Professor of Clinical Neurological Surgery, Washington University School of Medicine, St. Louis. Second edition. Pp. 552 with 348 illustrations and ten color plates. St. Louis, The C. V. Mosby Company, 1949. Price $15.00.

This volume is a combined second edition of two previous volumes published separately. The older volume, "Diagnosis and Treatment of Brain Tumors," has been rewritten and brought up to date. The "Care of the Neurosurgical Patient Before, During and After Operation" has been included in this volume.

There are chapters on surgical anatomy and physiology as well as methods of examination and surgical pathology of brain tumors. Then follow chapters on increased intracranial pressure, focal signs of tumors of the cerebrum, cerebellum and brain stem, and pituitary body. A full chapter is devoted to differential diagnosis of brain tumors and to anesthesia for intracranial operations. Two chapters are devoted to operative technic and procedures. One chapter covers spinal and peripheral nerve operations.

There is a full chapter on postoperative diagnosis. At the end of the book the author briefly reviews the history of neurosurgery and ventures predictions of things to come. The book is well written and profusely illustrated with many excellent reproductions, some in color. The treatment of brain tumors is thoroughly exhausted and seasoned with the author's mature judgment.

The book is of interest to neurologists and neurosurgeons, but it will find its greatest interest among young house officers and students.—H. F. S.

Diseases of the Heart. By Charles K. Friedberg, M. D., associate physician, Mt. Sinai Hospital, New York; lecturer in medicine, Columbia University. Pp. 1081, with 79 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $11.50.

The author of this book accomplishes his "endeavors to provide a comprehensive and integrated exposition of the diseases of the heart." No aspect of heart disease is overlooked. All recent diagnostic criteria are included, such as cardiac catheterization and angiocardiography, which, although especially applicable to congenital anomalies, are well integrated with simply detailed pathologic physiology and general mechanisms of dynamics. The discussion of treatment is excellent. All drugs and technics, recent and well tried, are included and evaluated both as to effect and as to rationale. Of special note is the common sense evident in the treatment of congestive heart failure, myocardial infarction, and subacute bacterial endocarditis. The author's basic teachings in the latter form an invaluable background.

This reviewer particularly liked the simple presentation and handling of the controversial forward and backward failure theories.

The illustrations are good in quality but sparse in quantity. The bibliography is complete.

This well written, easily read book is highly recommended to the medical student, general practitioner, and internist.—H. H. S.

A Textbook of Physiology. Originally by William H. Howell, M. D. Edited by John F. Fulton, M. D., Sterling Professor of Physiology, Yale University School of Medicine. Sixteenth edition. Pp. 1258, with 556 figures. Philadelphia and London, W. B. Saunders Company, 1949. Price $10.00.

This well known textbook was completely rewritten and published as the fifteenth edition in 1946, by the combined efforts of a large group of physiologists under the editorship of Doctor Fulton. It has now been brought up-to-date with the publication of the sixteenth edition. The most significant improvement is the addition of a new section (six chapters) on the endocrine system, contributed by Dr. Jane A. Russell of the department of physiological chemistry at Yale University. Other additions include a chapter on the cerebrospinal fluid by Rob-

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ert B. Livingston and one on the urinary bladder by T. C. Ruch. The section on digestion, previously written by George R. Cowgill, has been completely revised by Paul F. Fenton with the cooperation of Doctor Cowgill. The chapter on the functional activity of muscle, formerly by David P. C. Lloyd, has been rewritten by Samuel Gelfan. The section dealing with the circulation has been subjected to extensive rearrangement and revision. The discussion of the electrocardiogram, by H. E. Hoff, has been completely revised by L. H. Nahum and H. M. Chernoff. A new chapter by Donald H. Barron on "Blood Pressure: Its Establishment and Estimation" replaces the one by Eric Ponder on "The Velocity and Pressure of Blood Flow". The chapter on "Genetic Aspects of Physiology" by Walter Landauer has been omitted. Despite the inclusion of much new material, the number of pages has been reduced by the use of a slightly longer line and page. As in the previous edition, the strongest section is that dealing with the nervous system.—W. E. S.

From the Hills; An Autobiography of a Pediatrician. By John Zahorsky, M. D., St. Louis: The C. V. Mosby Company, 1949. Price $4.00.

After becoming accustomed to the somewhat stilted style in which this book is written, one cannot help being interested in the growth and development of the well known pediatrician, John Zahorsky.

Displaying a fine brand of courage for the sake of a visionary better future, his parents pulled up stakes in their native Hungary and moved to Cleveland, Ohio, when he was but 6 months old. Then, after a reasonably secure six years, they again pulled up stakes and, still for the sake of a visionary better future, moved to a farm in the Ozarks of Missouri. Here the elder Zahorsky, by training a blacksmith, had to learn farming literally from the ground up. The familial determination, however, that a better future required a better education carried over to the children and young John would let nothing deter him in his determinations to practice medicine.

One gets a vivid picture of Doctor Zahorsky's kindly and steadfast character from his soliloquies on a wide range of subjects. These range from eulogies on the character of his early teachers and medical preceptors to the beauty of certain weeds on his farm where he is living his "declining" years watching with unflagging interest all things that grow.—H. K. T.

A Textbook of Surgery by American Authors. Edited by Frederick Christopher, B. S., M. D., F. A. C. S., Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital. Fifth edition. Pp. 1550, with 1465 illustrations on 742 figures. Philadelphia and London, W. B. Saunders Company, 1949. Price $13.00.

"A Textbook of Surgery" is edited by Frederick Christopher, with contributions from nearly 200 outstanding men in the field of surgery. A volume like this is difficult to review because each section is a

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complete treatise on a specific subject and usually by a different author. Needless to say, this is by far the most comprehensive textbook of surgery which this reviewer has had the pleasure to review. As is stated in the preface to the fifth edition, the dominant plan of this textbook is to give the student a concise presentation of surgery which is characterized by the maximum authority. To merely quote the entirely new sections in this edition would take an entire page. It is obvious not only that this already fine textbook on general surgery has been brought up to date but that much new material is presented in a concise and organized manner with the liberal use of good illustrations and tables. One needs only to look at chapter VII which includes tendons, tendon sheaths, and fascial spaces to note the authority of the material presented. Injuries to tendons, for instance, are fully covered by Sterling Bunnell; infections of the tendon sheaths of the hand and fascial spaces, by Sumner L. Koch; infections of the tendon sheaths and fascial spaces of the foot and leg, by Manuel Grodinsky; tuberculous tenosynovitis, by Michael L. Mason; tumors of the tendons and tendon sheaths, by Arthur Purdy Stout; and ganglion, by Frederick Christopher. This is but one example of the coordination of valuable information assembled under the various subject headings.

This is undoubtedly one of the outstanding textbooks on surgery and is highly recommended both to medical students and surgical practitioners.—K. E. L.

Physiology of Heat Regulation and the Science of Clothing. Prepared at the Division of Medical Sciences, National Research Council. Edited by L. H. Newburgh, M. D., professor of clinical investigation, the Medical School, University of Michigan. Pp. 457, with 78 figures and 38 tables. Philadelphia and London: W. B. Saunders Company, 1949. Price $7.50.

These excellent contributions edited by Doctor Newburgh describe an enormous backlog of information concerning adaptations to climate: clothing and its physical properties, housing, food, work, culture, and physiologic adjustment.

Extensive sections on physiologic regulation of body temperatures include such mechanisms as blood volume changes, sweating and its fatigability, arteriovenous anastamoses, special role of extremities in heat economy, and changes induced by types of temperature which may be involved in acclimatization. A fictitious belief in the constancy of body temperature has hampered research on temperature as a variable factor.

Among the physical problems discussed are thermometry, heat transfer, heat loss from bare hands, the release of latent heat, and indexes of comfort. Laboratory and field studies indicate that physical measurements and subjective thermal impressions are not identical; the reason is obscure.

The science of clothing depends upon knowledge of physiologic adjustments to thermal stimuli, but clothing is seldom chosen on the criteria of physiology and physics. For instance, experimental net

tropical suits are cool but require "accustomization." Various factors determine correct clothing design in the world's seven "clothing zones" ranging from minimal clothing to maximal layers. These studies should improve our understanding of functional properties of clothing and future design for efficiency.

This abundantly documented book offers a concise survey of knowledge concerning the physiology of heat regulation and the science of clothing. The emphases upon gaps in knowledge should stimulate research.—E. M. L.

X-Ray Treatment; Its Origin, Birth and Early History. By Émil H. Grubbé, B. S., M. D., F. A. C. P., charter member and emeritus member of the Radiological Society of North America; charter member of the American Roentgen Ray Society; diplomate of the American Board of Radiology; associate fellow of the American Medical Association; emeritus member of the Illinois State Medical Society, and a member of the Chicago Medical Society. Saint Paul and Minneapolis, The Bruce Publishing Company, 1949. Price $3.00.

The author, a pioneer in the use of roentgen rays in treatment of disease, is credited by some as being the first roentgen therapist. The effect of the rays upon his hands led him to believe that the new rays would very likely be of value in malignant diseases, and he treated his first patient in January 1896, only a few months after Roentgen's discovery. Following a short review of the work with vacuum tubes leading to Roentgen's discovery of x-rays, the latter is briefly discussed. The remainder of the book is largely autobiographical and deals with the early use of this therapeutic agent by the author.—J. H. J.

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Trade News

Schering Establishes Another Endocrine Research Fellowship

Another research fellowship in endocrinology was recently established at Rutgers University by Schering Corporation, Bloomfield, N. J. According to Dr. James H. Leathem, endocrinologist and staff member of the New Jersey University's Bureau of Biological Research, the grant, valued at $2,300, is intended for the support of fundamental research by graduate students in the field of steroid hormones. Mr. Francis C. Brown, Schering president, stated that at Rutgers the new grant will facilitate study of several important but unsolved problems, including the relationship between normal steroid hormone functions and the protein metabolism of the body. Further research is being done on the effects of steroid hormone compounds upon the reproductive system. The effects of the androgenic hormones on fertility is also under study.

Importance of Detail Men Stressed at Convention

With competition in the pharmaceutical industry increasing more and more each year, the importance of the well trained detail man is becoming increasingly evident. In an address before the annual sales convention of the Ames Company, Mr. William T. Doyle, president of the Research Society, stated that continuing marketing research studies carried on by his organization shows the detail man to be an ever growing factor in the competition to introduce new products successfully, and to keep the old ones sold as well.

Mr. Doyle pointed out that his company's Prescription Audit Reports reveal that the antibotics and antihistaminics alone account for close to 20 per cent of prescriptions being written. Since these two types of therapy are less than ten years old, it is quite apparent how important new product development is to a company and also why it is so necessary to have a staff of well trained detail men to influence the doctors to prescribe them.

Also of interest was a recent study completed by the Research Society which showed that over a five day period physicians were being exposed, through detailing and direct mail, to a high of 85 trade names and a low of 61. Mr. Doyle stressed that the new language of trade names which is being built up necessitates continuous detail support, backed up by medical journal advertising, direct mail and a strong educational program with the pharmacist who after all is the link between doctor, manufacturer, and patient.

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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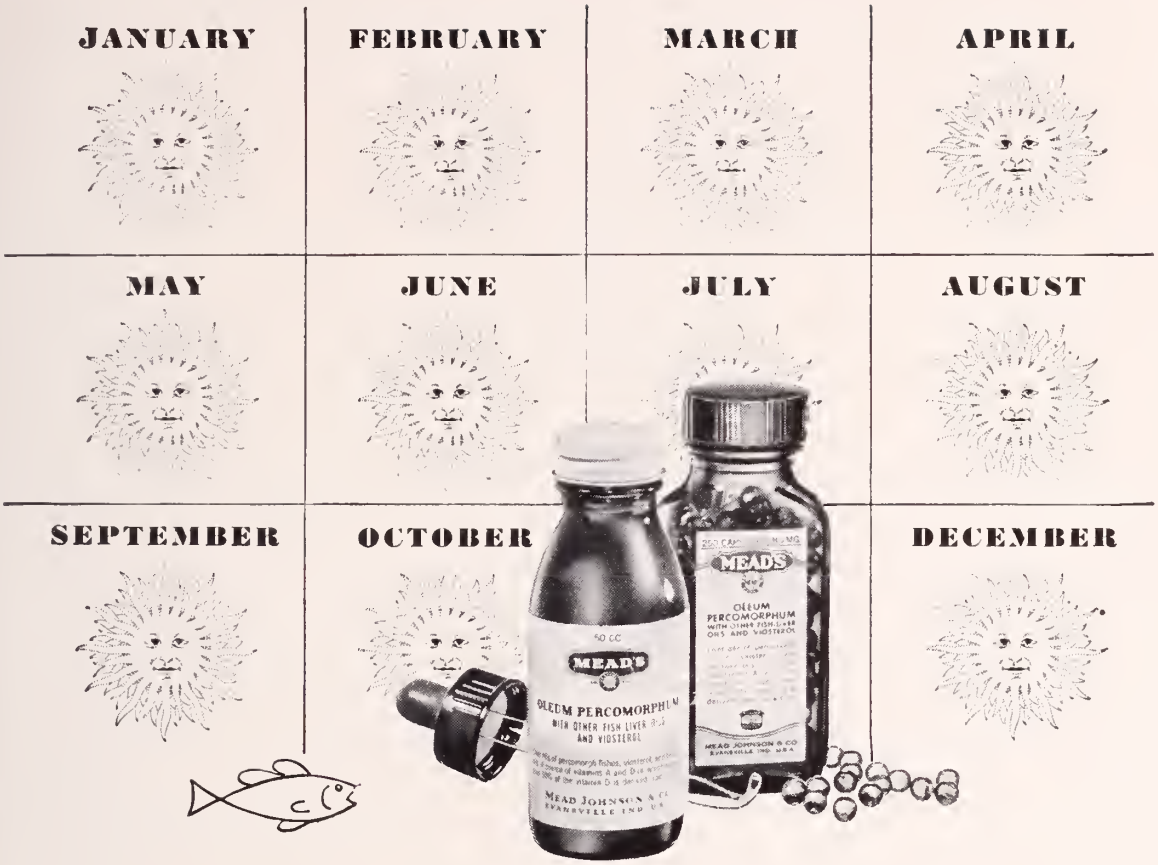

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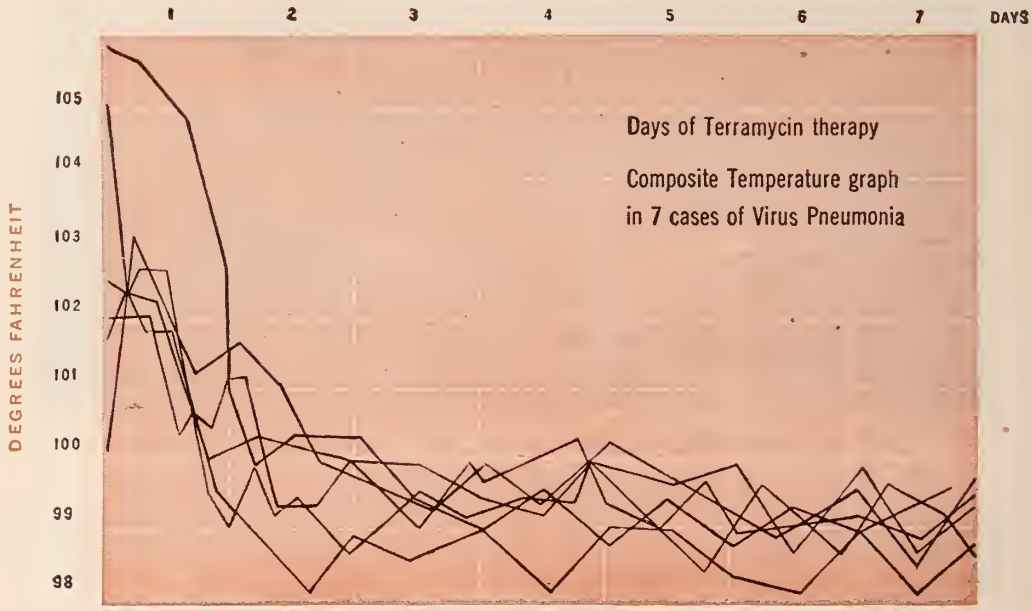

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1. *Blake, F. G.; Friou, G. J., and Wagner, R. R.; Yale J. Biol. and Med. 22:495 (July) 1950.*
2. *Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.*

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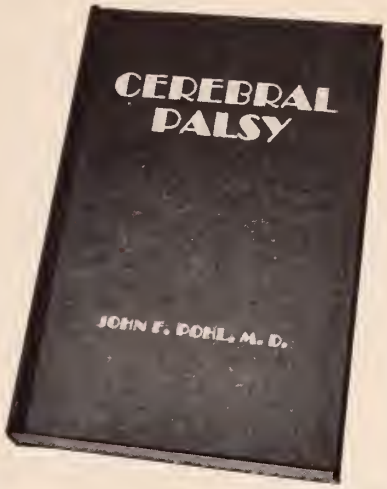

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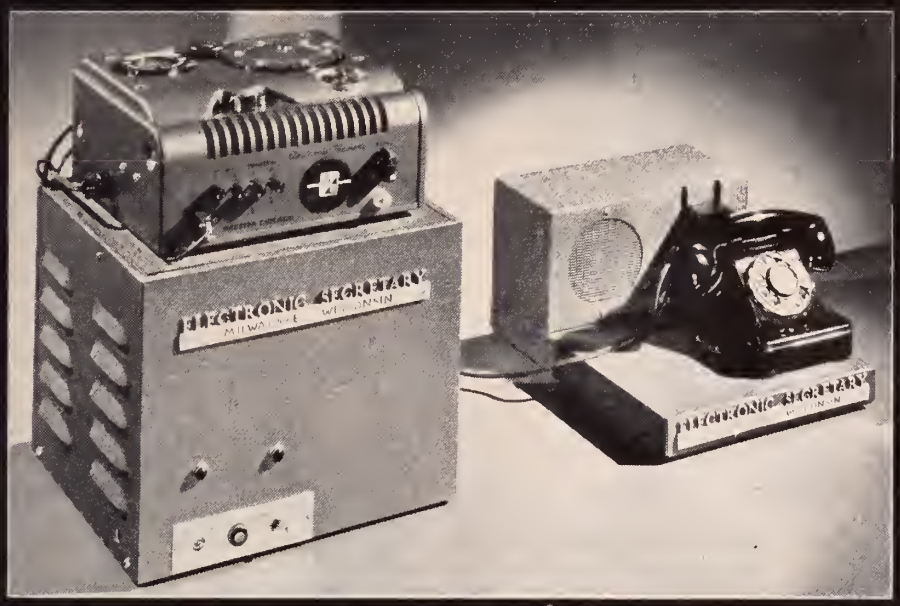

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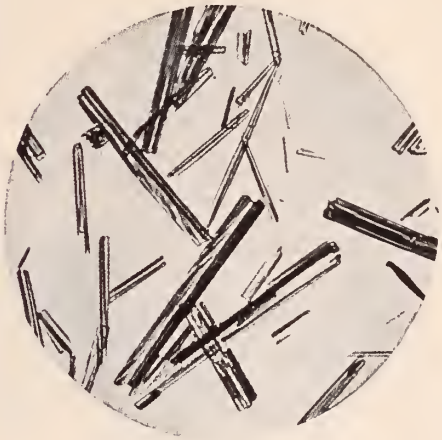

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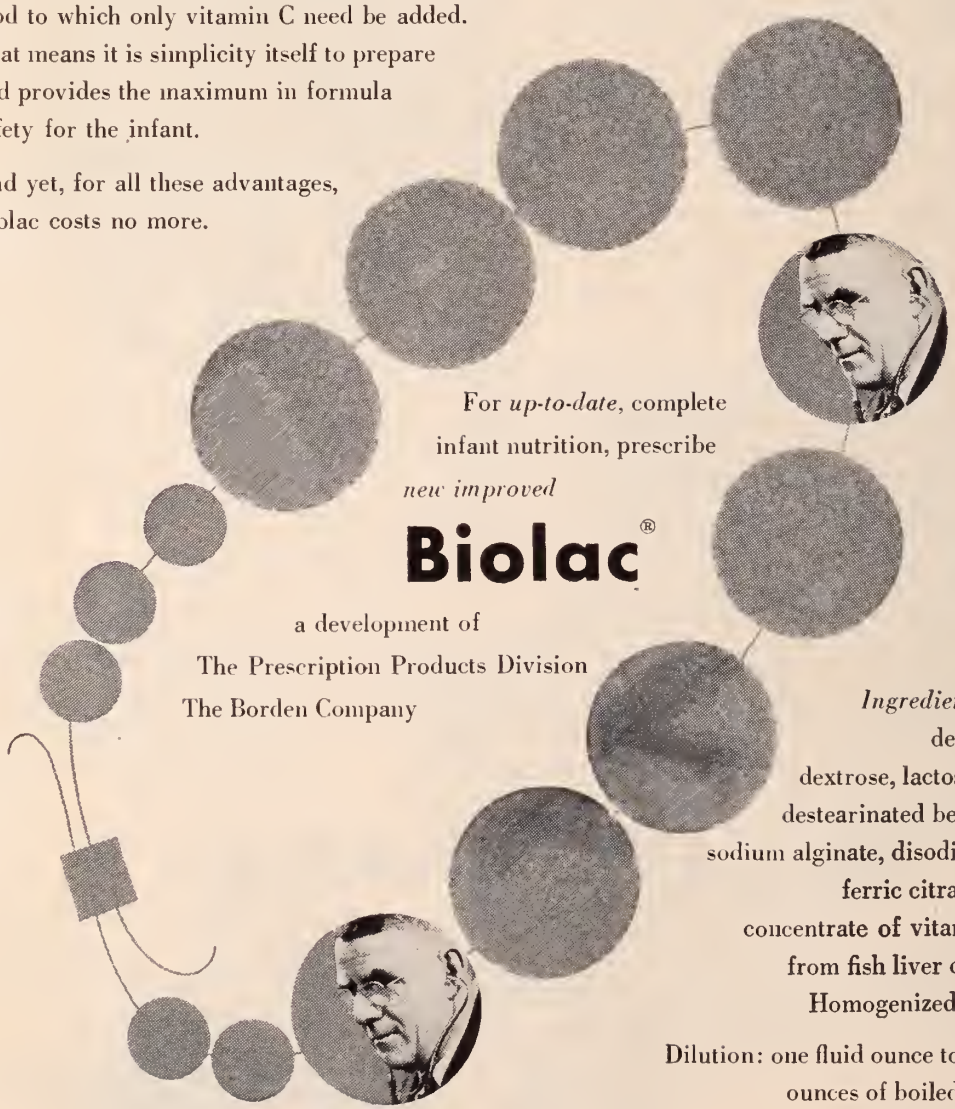

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1. Nesbit, R. M., and Glickman, S. I.: J. Michigan State M. Soc. *46*:664, 1947.
2. Dodson, A. I.: West Virginia M.J. *45*:1, 1949.
3. Seneca, H.; Henderson, E., and Harvey, M.: J. Urol. *61*:1105, 1949.

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(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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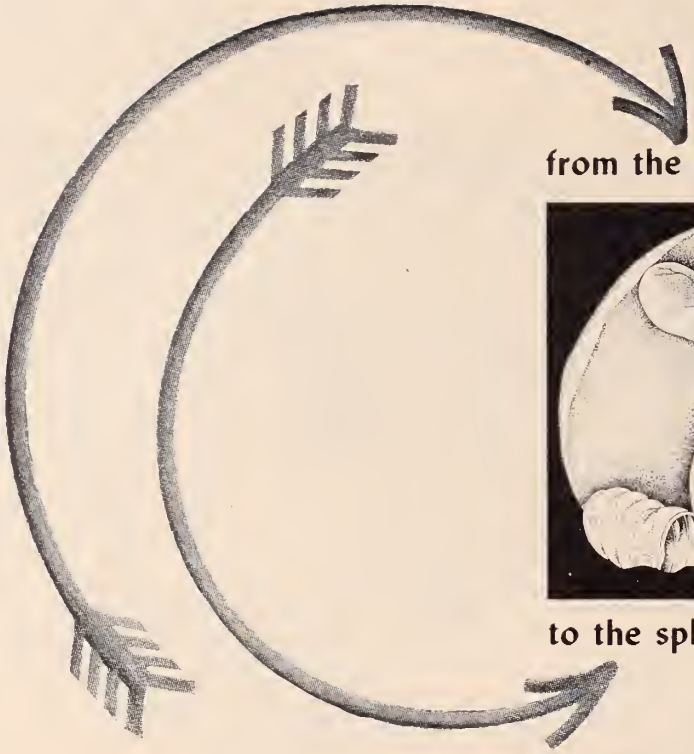

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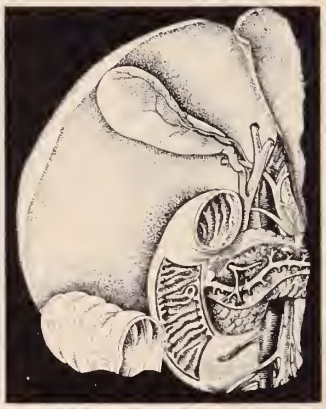

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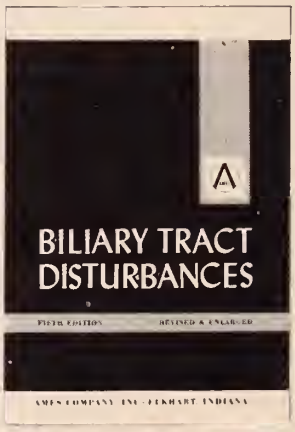

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« « « EDITORIALS » » »

National Defense and Blood Procurement

Civilian defense is an urgent matter in these days of cold and shooting wars. Planning for it, however, is difficult and exceedingly perplexing, since we do not know what form the attack will take. Attack with atomic bombs is the most destructive and, therefore, the most frightening. For this reason it is the method that is in everyone's thoughts and the one against which we are most anxious to be prepared. The kind of bombs that will be used cannot be predicted and, therefore, the defense planning is difficult. In this state of uncertainty, confusion, and anxiety, extreme measures are proposed without due consideration of the technical difficulties involved.

In case of such a disastrous attack as atomic bombing, it is certain that both whole blood and blood plasma will be needed for many who escape immediate death. The best method to plan for an adequate supply is the problem about which there is much difference of opinion. There are those who propose that universal blood grouping and typing should be undertaken in order to insure an adequate supply of donors. Under this plan a mass blood grouping and typing program is proposed. This means testing for the blood type of everyone throughout the nation. As the principal industrial centers are adopting this measure it has spread like contagion throughout the whole country. There are several reasons why we believe it is unwise, unnecessary, and impractical.

Since all experts agree that the situation at the point of bombing cannot be forecast with precision, there is agreement with the prediction that in the central area of a bomb explosion there would be devastating destruction of buildings, immediate death of a large number of people by burns, injuries, and shock. The result would be utter confusion and the rapid exodus from the area of all ambulatory persons. Those who are immediately destroyed would neither need medical aid nor be available as blood donors. Those who are ambulatory would be scattered over a vast area and their whereabouts unknown. In these areas the most urgent need would be ordinary first aid assistance, removing the injured to a periphery zone where adequate treatment can be carried out. It seems that under these conditions

no whole blood transfusing could be undertaken, although the less time consuming and immediately necessary infusion of plasma might be applicable for those in shock and those badly burned. The rescue services required to get these persons to a more satisfactory treatment area would certainly require the full time of all rescue parties. It seems certain that plasma will be more urgently needed and more practical than the whole blood during the first 24 hours and even longer. Whole blood will be needed only for those who have lost a considerable quantity of blood while plasma will suffice and is preferable for those in shock or suffering from severe burns. However, at a later time, when the injured have been removed from the central zone of attack to a peripheral area, where more organization is possible and more attention can be given to technical detail, whole blood will be needed. In these areas large quantities of whole blood will be required. Whole blood is perishable and cannot be stored for longer than two to three weeks. The peripheral treatment areas will, therefore, be largely dependent upon the known location of donors in the area.

In this emergency, even in the treatment areas there will hardly be time or personnel for the cross-matching of bloods between donors and patients. The only immediately usable donors will, therefore, be only those who are known to be universal, O, donors.

Universal blood grouping, mass grouping, would involve a tremendous job, requiring much material and the time of many technicians. Much of this effort would be wasted. Mass advance typing will not insure that donors will be where they are most needed or, if there, that they will be able to donate blood for others.

If mass or universal blood typing means the typing of all people, old and young, there will be much time wasted typing those who are over 60 and under 18 years of age. These constitute one-third of the population and are not used as blood donors under the present system of operating blood banks.

At the present time there is not enough blood typing fluid to carry out a mass typing program. There are only a few laboratories in this country that are preparing satisfactory fluids of high typing quality. It is true that these laboratories have been increasing the amount and quality of these fluids and over the next year or two perhaps they could accumulate an adequate supply for the accomplishment of such a program. It would require considerable additional capital and the time of a much enlarged personnel. The personnel for these laboratories would be small compared to the number of trained technicians that would be required to carry out the typing program.

It has been said that untrained persons could be qualified for this work with a few hours of intensive training. Granting that this is true—which we do not grant—it is doubtful if there are enough qualified trainors for the number of trainees that would be necessary. Past experience has shown that in the hands of especially trained technicians a careful supervision is necessary to surround the procedure of typing with the protection warranted when the danger associated with the transfusion of blood from one individual to another is considered.

Since it appears that the great need for whole blood will occur at the periphery of a bombed zone and since the immediate need is likely to be for universal, O, donors, mass advanced typing does not seem to be advisable. The needed supply of blood donors can be obtained by a plan of community registries where the names of all acceptable persons for donating blood would be kept on file. This registry can be easily and simply acquired through the hospital, Red Cross, and private blood banks now operating throughout the country. The filing would be done by blood type. In this way all over the country the O donors could be promptly identified and asked to report at appropriate locations for bleeding in case of emergency. The enlargement of the present capacity of blood banks for bleeding donors would soon supply a large amount of blood for processing for the production of plasma.

It is our opinion that defense councils will do well to give careful consideration to all the technical details when planning for whole blood and plasma in case of disaster, and to the opinion of those who have the greatest amount of experience in the procurement, distribution and processing of blood.

Last August the Blood Bank Committee of the American Medical Association met in Washington to discuss these problems with representatives of the American Red Cross Blood Bank Committee, representatives of the United States Public Health Service and others. In accordance with the opinion expressed by this group the American Medical Association committee adopted a resolution advising against mass or universal advance blood typing. The *Journal of the American Medical Association* on October 14 carried an editorial on the report of the committee and specifically quoted the resolution opposing mass blood typing. Because of the continued controversy on the subject and the difference of opinion among various local defense councils, the American Medical Association Committee was again called to a meeting which was held in Washington the latter part of October and in consultation with representatives from the American Red Cross and the United States Public Health Service reaffirmed the resolution adopted in August.

It is our opinion that mass advance blood typing is not only wasteful of personnel time and money but is inadvisable because of the technical difficulties which it will encounter.

The Future of American Medicine*

By H. H. CHRISTOFFERSON, M. D.
Colby

A FEW years ago I heard one of our great educators speak to a group of doctors about the future of American medicine. He said, "If your back cast is good, your forward cast will be equally as good." In our back cast over the past 50 years in building the house of medicine, we have many things of which we can indeed be proud.

Whoever heard, 50 years ago, of an x-ray machine in this county or in the next? Or whoever heard of a woman going to a hospital to have a baby? She was cared for at home. By a doctor? No—by a midwife! Whoever heard, 50 years ago, of diphtheria antitoxin? At times, in those days, whole families were blotted out by that dreaded disease. There were no tuberculosis sanitoriums. In 1900, tuberculosis, the great white plague, as it was then called, caused 2,175 deaths, while last year the death rate was cut down to 457. Fifty years ago there was no insulin for the diabetic patient. Nothing was known about concentrated liver extract for pernicious anemia. Penicillin and the sulfonamides also were unheard of.

These and many other items could be mentioned in the great advance of the science of medicine. Surgery has made similar advances during the same period, so that without question we can say that the science of medicine and the art of surgery have advanced more than any of the other sciences. As a proof of our great advance, we have extended the span of life about 20 years during the past 50.

Looking at the house of medicine from this point of view, we might easily fold our hands and say, "What more could anyone do?" But if you will read the articles that have appeared in various magazines, journals, and sometimes in the daily press, your attention will be called to the fact that the doctors of this country, members of the American Medical Association, are branded as a great American medical trust—a trust that is unmindful of the pleadings of the low income group of people for good medical care at a price that they can afford.

I would like to ask this one question: Is our public relations what it should be or what it could be? Do the doctors in this state really and truly realize that they have a community responsibility to the people of their community?

I am not saying that all doctors should be slaves, to be on duty 365 days in the year and 24 hours a day, but I am saying that the doctors of every community should so bind themselves together with a strict understanding, that some doctor is available for that community at all times, night or day. One reason why certain elements of our people are pressing for compulsory sickness insurance on a national scale is because some doctors of some communities have failed to take their full share of community responsibility.

Of late, the medical profession has seen fit to appoint public relations committees. The profession would do well to invite one or two public-spirited business men in each community to sit in on these public relation committee meetings. We might gain some real information by meeting with the lay people for whom we are caring. I can never forget what Dr. Olin West said to me in 1936. He said, "If we ever get socialized medicine in this country, it will be the doctors' own fault."

I wonder how many of us ever realize that big business is spending millions each year teaching young people how to create better public relations with the firms for which they are working. Let us look at a concrete example of what is taking place:

Not long ago I called at a doctors' office where two doctors are working as partners. I asked for Dr. X. The reply of the office girl was that he was not in.

I said, "Where is he?"
"I don't know."
"When will he be back?"
"I don't know."
"Are these his office hours?"
"Yes, but he isn't here."
"Is there anyone else waiting to see him?"
"Yes; there are six people waiting to see him."
"Have you any idea when he will be back?"
"I don't know."
Well, I thought, I'll ask for Dr. B.
"He isn't here, either."
"When will he be back?"
"I don't know."
"Have you any idea where I might find him?"
"I haven't the slightest idea where he is."

Now, to me this conversation did not create good public relations. I am sorry this happened in Wisconsin, so I can't say that is the kind of office girls they have in Illinois or over in Minnesota. It happened right in the state of Wisconsin.

Let's go back to the question of community responsibility. It should not be beyond the dignity of any physician, if he were asked, to become a member of the Board of Education; neither should it be beyond his dignity to take an active part in all matters of community activity. In order that a doctor might have some knowledge of business economic activities, it might be well for him to own some stock in a local business enterprise and sit in as a member of the board of directors.

I would like to point out also that every doctor, regardless of how busy he might be, should spend a few weeks each year at some postgraduate clinic,

* President's address before the House of Delegates of the State Medical Society, October 1, 1950.

because I believe this is the only way a doctor can keep abreast of advances in medicine. The public is watching the men who are doing such things, and they are looked upon as really outstanding men in their profession in their community.

I have another problem about which I think the doctors of this state might well be thinking, and that is the question of the high cost of medical education. I want it fully understood that I am not in favor of lowering the standard of medical education.

However, I believe that a loan fund could be established and placed in the hands of a trust company, and a committee of doctors as well as laymen could be appointed to make loans to medical students whose scholastic history, general character, and good behavior would indicate that they were worthy of such a loan, the loan to be secured by life insurance on the student until the debt is fully repaid. I have had very little experience with this form of lending money. I know, however, of two nurses and a lawyer who were sent through school following this sort of program, and each loan was promptly repaid soon after they began to work at their various professions.

Now, why bring up this subject? Because the public is saying that only the rich man's son can afford to study medicine, and I believe that in the ranks of the poor there is many a bright boy who would make an excellent doctor.

It is my recommendation to the House of Delegates that it authorize a loan fund for those who need assistance in financing a medical education. This will require establishment in such a fashion that it can be built from donations as well as assignment from the dues account. It must be managed so that loans will be repaid as recipients are able to do so. Above all, it must be under direction that has continuity and a broad understanding of the purpose of the fund. It is my belief that recipients of such grants should preferably be those enrolled either at Marquette University or at the University of Wisconsin and whose intention it is, as citizens of Wisconsin, to practice in Wisconsin after graduation. But those are details to be worked out later. Let the House recognize the general principle, and let the Council work out the details.

We, the doctors, and our two fine medical schools, are being accused of trying to restrict the enrollment of medical students. Nothing is farther from the truth, and the attention of the profession as well as the public should be directed to the facts as they exist. As those of us who have been trained in the field of medicine know, the process of producing a physician is a costly and complex one. With the dramatic advances made in medical science during your lifetime and mine, the demands placed upon medical education have increased so that more laboratories and more teaching beds are needed as basic training requirements. In spite of all this, our two medical schols show a fine record of utilizing facilities to the utmost in order to produce as many physicians as possible without lowering the quality of education and practical training. I am sure it should interest you to know—and it should interest the public and our legislators to know as well—that the University of Wisconsin has increased its output to a marked degree during the past decade. Prior to 1940 our state medical school could carry only half of its students through to graduation. The rest were required to go elsewhere for the completing of their medical education, beyond the first two years. When the two year course was discontinued in 1940, the school was able to accept 70 students, and that seemed to be the maximum number that could be adequately trained, on the basis of teaching beds and existing facilities in the basic sciences.

During the war, Wisconsin participated in an accelerated program; and, starting in 1946, 80 students were accepted on a permanent basis. Anyone close to medical education knows that the accelerated program placed a strain on students, faculty, and facilities alike, with a shortening of education which could be excused only on the basis of the emergency which existed.

Since 1946 the basic class level of 80 has been retained, in anticipation of improved facilities through the completion of the addition to Wisconsin General Hospital and other building programs related to medical education. However, it is important to point out that those responsible for medical education at our state university are not too happy about the low priorities being given the building of facilities in the basic sciences. Hospital teaching beds are just part of the answer to improved medical education at the University of Wisconsin. Better and more laboratories are essential if the quality of medical education is to be maintained in the state.

The same basic consideration holds true at our other medical school, Marquette. The administration of Marquette University School of Medicine is to be commended for the efforts it has made to utilize fully the facilities provided. Through administrative effort and careful planning it has managed to maintain a class level of 100 students per year. Until such time as more teaching beds and laboratories are provided, there is little promise of an expansion in the training program offered at this school.

In summary, I think it essential that we all direct our thinking on medical education to facts, and not fancies. The training of a physician in this complex age of science is such that enrollments in medical schools and the ultimate production of physicians cannot be controlled in the manner of turning on water. The public should understand the importance of maintaining basic standards in medical education, and not be confused by the politicians, intent on discrediting the entire profession of medicine through the dissemination of half-truths or downright lies. It is our responsibility to interpret these problems to leaders in our communities and in our state so that the problem of physician supply will be approached with intelligence rather than bigotry.

Nontuberculous Diseases of the Chest

By L. L. ALLEN, M. D., F. C. C. P.
Milwaukee

L. L. ALLEN

A graduate of Northwestern University Medical School, Doctor Allen is engaged in private practice in Milwaukee. He is a member of the medical staff at Muirdale Sanatorium and is also on the staff of the Milwaukee Health Department, in the tuberculosis division. A fellow of the American College of Chest Physicians and a member of the Academy of Tuberculosis Physicians, he is on the teaching staff at the Vocational School for Nurses.

HAVING written several papers on various phases of tuberculosis both pulmonary and extrapulmonary, covering diagnosis, the management, and treatment, I am now presenting the problem of nontuberculous lesions of the chest, those which so frequently masquerade as pulmonary tubercolosis, from x-ray presentations as well as clinical manifestations.

The purpose of this paper is to emphasize the importance of a careful history, which will give the clue to most diseases when given by an intelligent patient.

Since my work is in the field of tuberculosis, I use the following formula: (1) careful history in every detail; (2) a complete physical examination; (3) Mantoux skin test; (4) fluoroscopic and roentgenographic examinations; (5) sputum examination, including cultures; (6) if need be, gastric aspirations (after fasting) by cultures; and (7) guinea pig inoculation.

If these methods fail, the work is cut out for a differential diagnosis which is frequently difficult to make.

It is timely to mention here that a good laboratory personnel is indispensable in assisting the physician in arriving at a correct diagnosis. Many of our large cities offer such efficiency at their public health centers, and practically every grade A hospital boasts of this scientific service.

Since all of the diseases I am discussing in this paper came under my observation either at Muirdale Sanatorium or in my private office with a diagnosis of pulmonary tuberculosis, I would like to stress the importance of not relying upon the x-ray film alone in making a diagnosis of pulmonary tuberculosis. The common use of the x-ray has robbed many good physicians of their acumen, especially in clinical study of their patients from the various angles of investigations.

While the majority of my remarks may be common knowledge to the phthisiologist, I trust that they may be of some interest and value to those who are engaged in the general practice of medicine.

I would like to give a brief survey of the mycotic diseases, in that a few of my case histories and slides will fall under this group.

As physicians well know, fungi are filamentous plants of single structure which grow in irregular masses. They may be parastitic, saprophytic, or facultative parasitic. The fungi which attack the bronchi, lungs, and other organs of man belong to the following groups: (1) the yeast-like fungi causing coccidiosis, blastomycosis, and moniliasis; or (2) mold-like fungi, a group of which is nonpathogenic, while a higher group causes aspergillosis, and a still higher group causes actinomycosis.

Pneumomycoses have many pathologic features manifesting chronic granulomatous lesions similating syphilis, tuberculosis, and neoplasms. These variations reveal themselves in the skin and bones most frequently. Very often the skin is involved without any respiratory involvement.

I would advocate here that any skin lesion with questionable diagnosis or with direct diagnosis of fungus disease should be checked by x-ray of the chest to help complete the diagnosis because of the pathogenesis. Microscopic diagnosis is made by treating the sputum or pus with a solution of 10 per cent sodium hydroxide. Sabouraud's medium and blood agar plates under aerobic and anaerobic conditions are one means of cultivation. Yeast is recognized by its buds and mycelia.

It is not my intention to go into any detail on the discussion of mycotic diseases, because any one type would take a complete paper alone. My enthusiasm has prompted me to mention these diseases, which come to my notice frequently enough to give warning that they should not be overlooked and wrongly diagnosed. Many of our medical men live and practice in sections where these diseases are more prevalent than here in Wisconsin.

Coccidioidomycosis, for example, is caused by the yeast-like fungi which are quite prevalent in the Southwest. In California and Arizona, where many of our soldiers were stationed during the last war, many cases have been reported.

In spite of the fact that this disease is reported to be frequent in Negroes, the only 2 cases I have seen were among Caucasians. Both patients had negative reactions to Mantoux tests but gave positive reactions to the coccidioidin skin test; also, the sputa produced the Coccidioides immitis, the parasitic mold. Animal inocculation (guinea pig) produced the disease as another diagnostic feature.

Patients who recover from coccidiosis have earmarks of calcifications in the lungs similar to histoplasmosis, which is often confused with the calcifications seen in apparently healed tuberculosis. Patients with severe coccidiosis have all the exaggerated symptoms and signs of pulmonary tuberculosis plus ravishing skin and bone lesions which terminate fatally.

Bronchiectasis

Bronchiectasis is too often diagnosed as pulmonary tuberculosis because of the clinical manifestations, such as a severe cough with profuse expectoration and frequent hemoptysis.

Preventative measures are the paramount issue here, because when this disease becomes chronic a cure comes only through radical surgical treatment, which is also limited.

Some of the etiologic factors are pneumonia in young persons, influenza and postpneumonic bronchial obstruction with atelectasis, or a rather poor cough reflex in infants, due to the small caliber of their bronchi, leading to obstruction.

Cicatricial narrowing of the bronchus may occur secondary to acute or chronic tracheobronchial inflammation which impedes endobronchial drainage distal to the site of obstruction. This often leads to a chronic infection which destroys the structures in the walls of the bronchi. Foreign bodies which have been retained for a long period and extrinsic lymphatic glandular pressure play a part in this role.

Frequent x-ray examinations of the chest in children and precision bronchoscopic procedures are of great assistance in allaying and removing the cause. Congenital bronchiectasis due to malformation has its permanency.

I am presenting a photograph and the history of a case of an upper lobe bronchiectasis which should be of some interest to my readers. Lipiodol with bronchograms is the best diagnostic method, with, of course, differential laboratory findings.

Mitral Stenosis

Miliary densities due to or associated with rheumatic mitral stenosis also present x-ray films which are often mistaken for pulmonary tuberculosis. Systolic and presystolic murmurs confined to the apex of the heart may be a lead to this finding.

Fluoroscopic enlargement of the left auricle with linear and nodular infiltration in the lower half of both lungs plus a final fibrosis gives one quite a definite picture of a chronic mitral stenosis. The x-ray film will reveal this picture well defined.

With the obstruction of the blood flow through the mitral valve, there is a draining back of blood in the pulmonary area, with enlargement and engorgement of the capillaries, causing edema of the lungs with final pulmonary fibrosis; frequent hemoptysis is often a cue.

I observed 2 such cases, in which the patients were young men who had miliary fibrosis, during my service on the draft board of the last world war. Both men had mitral stenosis.

Cystic Lung Abscess

We have had several cases of cystic disease of the lung diagnosed previously as pulmonary tuberculosis with multiple cavitations.

There are two very distinct types, one congenital and the other acquired. The congenital type on pathologic studies reveals bronchial elements, such as glands, smooth muscle fibers, cartilage, and stratified ciliated epithelium; whereas the acquired type does not contain muscle or cartilage. These findings in my experience have been observed from lobectomies and pneumonectomies and by autopsy.

Clinically, recurrent attacks of persistent cough or dyspnea, with x-ray films of single or multiple cavities without soft parenchymal infiltration, may give one the suggestion of cystic lung disease in cases in which there is a glary expectoration and a negative sputum for acid-fast bacilli.

A differentiation from lung abscess, bronchiectasis, spontaneous pneumothorax (pocketed), emphysematous blebs, and tuberculous cavities must be made.

There is no attempt here to delve into the fundamental details of this disease, which would require more than a single paper on this one subject alone. I merely wish to mention another masquerader of pulmonary tuberculosis and present the history of a case of one of my patients who had a single congenital cyst which became secondarily infected after a tonsilléctomy.

Pneumonitis

In my opinion an atypical pneumonia may be considered a syndrome in which the pulmonary lesion is one manifestation of a generalized infection.

The onset may be gradual, insidious, or sudden. It is characterized by an influenzal-like onset, with a temperature around 102 F. and pulse rate ranging from 90 to 110, frequently out of proportion to the extent of the local pulmonary lesion.

There is no definite organism to identify the disease etiologically. Physical findings are not compatible with the x-ray film, in that there is usually a paucity of rales. In many of these cases the condition is diagnosed as pulmonary tuberculosis, which is not proved by scrutinizing laboratory investigation.

The course of the disease is generally short, about six weeks or less, and terminates by resolution.

I am presenting a photograph of this type which cleared in six weeks, leaving no trace of the former x-ray findings.

Loffler's Syndrome

This disease reveals a pulmonary infiltration, a blood eosinophilia of 10 to 60 per cent, a low grade fever, leukocytosis and an elevated sedimentation rate.

There are few chest findings on physical examination, but x-ray shows pulmonary infiltrations in various parts of the lungs, sometimes localized, often appears as a tuberculous lesion, and has to be differentiated. If watched closely by fluoroscope or roentgenogram, one will find that the densities disappear early and they do not cavitate. This disease is supposed to be on an allergic basis.

Sarcoidosis

The dissemination of this disease, with involvement of the respiratory system with its characteristic syndrome, registers itself in the disguise of pulmonary tuberculosis. The skin lesions may not appear early; the subcutaneous nodules, which show a predilection for the extremities, may be overlooked; also there are skeletal changes, especially in the fingers and toes, and trophic changes of the nails. Lymph node involvement is often gross enough to suggest Hodgkin's disease, or the skin lesions may simulate lupus vulgaris.

This disease requires careful differential diagnosis with biopsy of local lesions. I have seen several of these cases in which the patients were Negroes, and all previously diagnosed as having tuberculosis.

The general good health of these patients, in contrast to the extensive lung involvement, is suggestive that the patient is not tuberculous. There is frequent regression of all lesions spontaneously, but a transition into pulmonary tuberculosis, which often happens, makes it a constant threat.

Cancer of the Lung

Cancer of the lungs may give all the classic signs and symptoms of pulmonary tuberculosis. Whether this disease is on the increase or whether it is due to more scientific diagnosis by means of mass x-raying and bronchoscopy as well as more skill in clinical and laboratory diagnosis is a question.

My service at the City Health Department has given me the opportunity to pick up an occasional case of this type by means of mass x-raying. Cough is a frequent early symptom, but hemoptysis generally brings the patient to the physician. Primary carcinomas of the lung are bronchogenic, originating either from the main bronchus, or segmental or peripheral bronchi.

Early diagnosis may offer a successful pneumonectomy and tentative cure. A metastasis to the lung must not be interpreted as a primary lesion if surgical treatment is contemplated.

Diagnosis is often made by bronchoscopy where there is a tumor of the main bronchus. A biopsy section is frequently available. Segmental bronchus may offer secretions to the bronchoscopist for laboratory study.

Silicosis

I presume that this industrial disease is so well known that it would seem useless to discuss it as a masquerader of pulmonary tuberculosis. Let me emphasize a careful history here. Silicosis has a striking resemblance to miliary tuberculosis, and this mistaken diagnosis is frequent. Symptoms of cough, hemoptysis, dyspnea, and expectoration, with physical findings of lung impairment with frequent rales, have sent many patients to Muirdale Sanatorium with a diagnosis of pulmonary tuberculosis.

I must admit that silicosis is frequently a contributing cause of pulmonary tuberculosis, and often one sees the two diseases combined.

In Wisconsin a patient must have tuberculosis with his silicosis in order to receive compensation. However, I have seen silicosis of the second and third stages just as disabling as the combination disease, cardiac failure being the damaging result.

CASE 1.—*Blastomycosis; Tuberculosilicosis*

J. J. McA., a Negro male, 51 years of age, had been a moulder in a foundry for 15 years, with basement living quarters.

On inspection an ulcer was found on the right cheek and right shoulder.

Chest findings suggested pulmonary tuberculosis, silicosis, and blastomycosis.

Fig. 1.—Pulmonary tuberculosis with blastomycosis of face and left shoulder.

The Wassermann and Kline reactions were negative; sputum was positive for acid-fast bacilli; Blastomyces dermatitidis was obtained from skin lesions but none was found in the sputum cultures.

The patient was given heavy doses of potassium iodide by mouth in spite of the complications of tuberculosis. The skin lesions cleared completely in eight months, and within two years the tuberculosis became apparently arrested, with negative sputum and gastric cultures.

The patient was discharged from the sanatorium with a diagnosis of an apparently arrested pulmonary tuberculosis and cured blastomycosis. The silicosis did not show retrogression, as seen in second film, taken Feb. 4, 1943.

CASE 2.—*Blastomycosis*

H. D., a white male aged 26 years, had worked several years in a basement garage. He had coughed for three years before seeing a physician. This patient came to my office for treatment. On fluoroscopic examination I made a tentative diagnosis of pul-

Fig. 2.—Blastomycosis

monary tuberculosis involving the upper right half of lung with basal emphysema and involving the lower half of the left lung with emphysema in the upper half. Skin lesions were questionable, since the patient had diabetes. I sent him to Muirdale Sanatorium on my service, where he had a complete workup. X-rays revealed massive consolidation of both lungs, upper right, and lower left. He had ulcerated lesions on the right shoulder, both arms, and right thigh. All sputum and gastric aspirations were negative by culture for acid-fast bacilli. Urine and blood sugar were positive for diabetes mellitus.

Skin abscesses were positive by cultures for Blastomyces dermatitidis. His sputum also contained blastomyces.

The patient died, and an autopsy was done.

The final diagnosis was diabetes mellitus and systemic blastomycosis of the skin, bones, lungs, and pleurae.

CASE 3.—*Blastomycosis*

S. M., a white male aged 43 years, had been a crane operator in a foundry for eight years. His living conditions were very poor. His symptoms prior to admission were cough, pain in the chest, dyspnea, and frequent hemoptysis. His case was diagnosed as one of pulmonary tuberculosis, and he was sent to the sanatorium.

Fig. 3.—Blastomycosis.

Chest findings showed a heavy consolidation in the upper one third of lung on the left, with minor changes on the right side. There was a large abscess on the left arm near the elbow and similar ulcerated abscesses in the gluteal region. Wassermann and Kline tests elicited negative reactions. Sputum and gastric aspirations were negative for acid-fast bacilli. Sputum cultures were positive for blastomyces; also, cultures taken from local abscesses of the skin were positive.

An autopsy was performed.

The diagnosis was systemic blastomycosis of skin, ribs, body of sternum, clavicle, occipital bone, lungs, and pleurae.

CASE 4.—*Actinomycosis*

J. S., a white male aged 51 years, had been a stationary fireman in a basement apartment house and also lived in the same basement.

He had apparently been in good health until a chill suddenly developed while he was cleaning his furnace. He later contracted a severe cough, expectoration, pain in side and hemoptysis.

His symptoms subsided before he saw his family physician, but, when he did, a diagnosis of pulmonary tuberculosis was made and admission to a sanatorium advised.

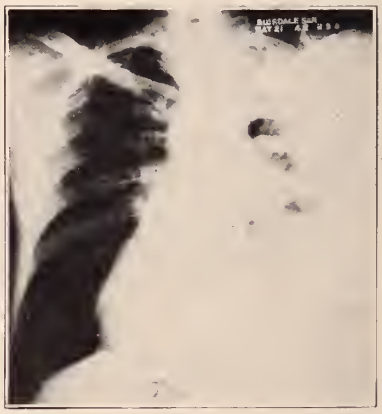

Fig. 4.—Actinomycosis with empyema.

On entrance to Muirdale Sanatorium, the patient had become quite ill, and had a high temperature severe cough, and pain in the right side. The sputum was purulent; x-ray revealed a heavy infiltration in the upper one-half of the lung with an empyema in the lower half; aspiration showed a heavy greenish pus. I might add that he had marked clubbing of his fingers.

Wassermann and Kline reactions were negative; sputum and gastric cultures were negative for tuberculosis. The laboratory diagnosis from cultures of Sabouraud's medium revealed branching mycelia of Actinomyces bovis in the sputum and pus from the empyema.

This patient was discharged from Muirdale Sanatorium to the County General Hospital, where he died. Autopsy confirmed the laboratory diagnosis of actinomycosis.

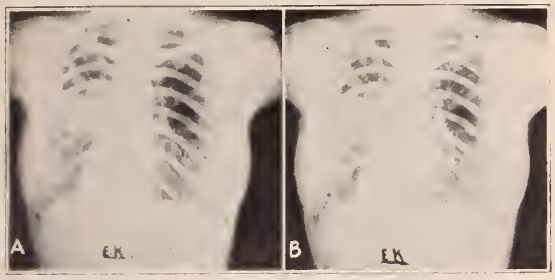

Fig. 5.—Aspergillosis.

CASE 5.—*Aspergillosis*

E. K., a white female aged 17 years, was a school girl. She was sent to Muirdale Sanatorium as a tuberculous patient because of findings on routine x-ray examination. Soon after admission, her disease progressed, with clinical manifestations of cough, low grade fever, and hemoptysis.

Mantoux test was negative by all strengths, Wassermann and Kline reactions were negative, and sputum cultures and gastric cultures were negative for acid-fast bacilli; x-ray revealed a heavy infiltration from the left hilum throughout the midzone and lighter infiltration toward the apex and toward the base. She had subacute enteritis.

A fungus resembling Aspergillus fumigatus was isolated in sputum cultures and gastric lavages.

The patient was discharged from Muirdale Sanatorium with a diagnosis of aspergillosis. Clinically, she was nontuberculous.

Two years later she entered Mount Sinai Hospital, with the same diagnosis, with no departure from our original x-ray findings.

CASE 6.—*Moniliasis*

S. Y., a white male aged 22 years, was a shoe salesman. His father had died of tuberculosis, but the patient had had no contact with him. This patient had had a cough and expectoration four months before consulting a physician. He lost considerable weight and began to run a low grade fever, which made him seek medical aid. He was sent to Muirdale Sanatorium on clinical findings. X-ray revealed an extensive infiltration practically throughout the right lung, with a scattered infiltration in the upper one-half of the left. Wassermann and Kline reactions were negative, the tuberculin reaction was negative, sputum cultures and gastric cultures were negative for acid-fast bacilli, and guinea pig inoculation was negative for tubercle bacilli.

Fig. 6.—Moniliasis.

Budding cells and mycelia of monilia were seen in sputum smears. Cultures on Sabouraud's medium revealed Monilia albicans.

The diagnosis was moniliasis.

CASE 7.—*Nontuberculous pulmonary fibrosis*

M. H., an Indian woman aged 54 years, came to my office complaining of cough, dyspnea, and hemoptysis. An x-ray was taken of her chest and she was sent to Muirdale Sanatorium immediately because of her grave condition. She was assigned to my service. My first impression of her x-ray was that of a bilateral pleurisy with effusion. The second presumptive diagnosis was pericarditis with effusion. Frequent aspirations did not produce anything. A few rales were heard in the upper quadrant of the chest; heart tones were faint and distant. The patient was asthmatic, with marked emphysema of the upper chest.

M.H. died a few days after admission, but all laboratory tests were executed before her death. Wassermann and Kline reactions and spinal fluid cultures were negative; the Mantoux test elicited a positive reaction. Sputum cultures and gastric cultures were negative for acid-fast bacilli; guinea pig inoculation was negative.

Fig. 7.—Pulmonary fibrosis.

Autopsy findings were various, particularly the cardiac pathology. There was an extensive pulmonary fibrosis bilaterally with adhesive pleurisy but no fluid in the pleural spaces or pericardial space. I would like to add that this patient had a marked mitral stenosis with thickening and adhesions of the mitral segments; the left auricle was unduly enlarged, and the right ventricle hypertrophied, developed through pulmonary resistance.

This pathologic change was mentioned in my previous notes describing a pulmonary fibrosis of a milder type. My film of this case fell into the hands of one of my contemporaries and was lost.

Diagnosis was extensive pulmonary fibrosis with cardiac failure.

CASE 8.—*Primary and Metastatic Carcinoma*

J. D., a white male aged 56 years, the head of an industrial plant, was sent to my office for a diagnosis. His chief complaint was cough and apprehension, and he had fear of impending death. He was in excellent physical condition; no rales were heard in the chest, but x-ray revealed atelectasis of the apical region of the right lung. This was as far as I could go in my diagnosis of the chest.

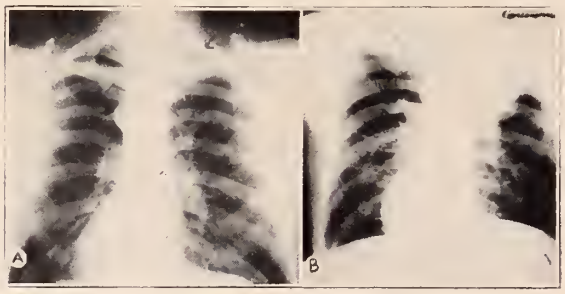

Fig. 8.—Primary carcinoma of the upper right lobe bronchus, with atelectasis.

J.D. had been seen by the best physicians in the city, and all laboratory tests had been made, with negative results.

He left Milwaukee for one of our famous diagnostic institutions and came back with a tentative diagnosis of occult syphilis. Previously Wassermann and Kline and spinal fluid tests had given negative reactions. He was given potassium iodide as a preliminary to the arsphenamines. Immediately his disease metastasized. My second film, figure 8b, gives the answer.

This was a primary carcinoma of the right segmental bronchus which caused the atelectasis. Thus far I was right, but not near enough. A pneumonectomy in the first stage could have saved a life. Autopsy gave the conclusive diagnosis: primary carcinoma of the bronchus with metastasis.

CASE 9.—*Cystic Lung Abscess*

R. H., a white male aged 21 years, was a student. He was sent to Muirdale Sanatorium because of cough, profuse expectoration, fever, chills, and malaise with loss of weight.

X-ray revealed a large abscess cavity in the right midlobe. However, it was not too well defined and was suggestive of an empyema with a bronchopleural fistula because of the purulent sputum. I did a diagnostic pneumothorax in the case, which proved the abscess of the lung.

This patient left the santorium after some improvement in his general health, because he had considerable relief from postural drainage of his abscess.

Two years later he returned with a diagnosis of pulmonary tuberculosis, with his abscess still present.

He ended up with a right thoracoplasty and lobectomy of the abscess area. The cyst had all the

Fig. 9.—Cystic abscess of the lung.

characteristics of a congenital cyst by pathologic and microscopic observation.

CASE 10.—*Metastatic Carcinoma*

L. T., a white male aged 48 years, was a merchant. This patient came to my office complaining of cough, dyspnea, and hemoptysis. Previously he had been treated several months for gastric distress and was finally told that he had pulmonary tuberculosis.

An x-ray revealed a metastastic carcinoma of the lungs. Having seen so many of this type, I was sure of my diagnosis without further analysis.

Fig. 10.—Metastatic carcinoma of the lung, with primary lesion in stomach.

An autopsy was performed, and the primary lesion was found in the pyloric end of the stomach.

It is well to remember here, too, that gastric symptoms help to complete the syndrome of pulmonary tuberculosis.

CASE 11.—*Syphilis of the Lung*

J. J., a Negro male aged 28 years, was a waiter. He was sent to Muirdale Sanatorium because of massive hemorrhage. Physical findings revealed an aortic insufficiency and impairment of both lungs

Fig. 11.—Syphilis of lung.

with scant rales. X-ray findings were not quite the pattern of pulmonary tuberculosis. The butterfly appearance of the bilateral lesions should be noted (fig. 11). Wassermann and Kline reactions were positive, but sputa were negative for acid-fast bacilli.

The patient left the institution against medical advice. A few days later he had a hemorrhage and died suddenly.

I received permission from his mother to do a limited autopsy, and I found marked pulmonary fibrosis with small acute and subacute inflammatory areas, multiple small gummas, red and gray nodules which had the consistency of rubber, no caseation or tuberculosis on cut sections, and small gummas which studded the pleurae. There were grayish patches near the mouth of the coronary arteries and yellowish rubbery thickness on the aortic valves.

The diagnosis was pulmonary syphilis and luetic aortitis with valvular involvement.

The only other case of syphilis of the lung that I have seen was that of a white patient, foreign born, 34 years of age, who had a bilateral pleurisy with effusion, pleurae studded with large gummas, and an acute pneumonic inflammatory process of the lung which was diagnosed grossly and microscopically as syphilis by the pathologist.

CASE 12.—*Pneumonitis (Atypical Pneumonia)*

H. C., a white male aged 31 years, was a traveling salesman. He was stricken suddenly with chills, fever, cough, expectoration, and complete exhaustion. After his symptoms had subsided, he went to the office of his private physician, who took an x-ray, then sent him with his x-ray to me for admission to Muirdale Sanatorium as a tuberculous patient.

He refused to enter a tuberculosis sanatorium, so I put him in a private hospital where all tests were made for tuberculosis and other diseases. The Mantoux test gave a negative reaction. The sputum and gastric aspirations were negative, as were also guinea pig inoculation and Wassermann and Kline reactions.

Fig. 12.—Pneumonitis.

During the wait to sacrifice the guinea pig at the end of the six weks, the patient recovered completely and returned to work. This case, in my opinion, was one of atypical pneumonia.

CASE 13.—*Tuberculosilicosis*

P. S., a white male aged 56 years, had been a sand blaster and moulder for 22 years.

This patient had tuberculosis and silicosis. The tuberculous cavity in the upper lobe should be noted. I have mentioned this combination before in this paper and, therefore, will only emphasize the importance of an industrial history.

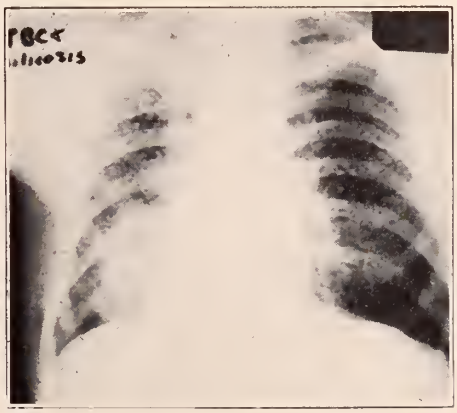

Fig. 13.—Tuberculosis and silicosis.

CASE 14.—*Upper Lobe Bronchiectasis*

The case of T. M., a white girl aged 18 years, was particularly interesting to me because of the circumstances involving her diagnosis. She entered Muirdale Sanatorium the summer of 1916, my first year as a staff member. Our staff was limited, so we had to divide the work in such a manner as to cover the departments that were not filled with a personnel. My side work after the routine service at the bedside was to cover the laboratory duties.

The patient in question entered the hospital because of a massive hemorrhage. Physical examination revealed a large upper lobe lesion with marked

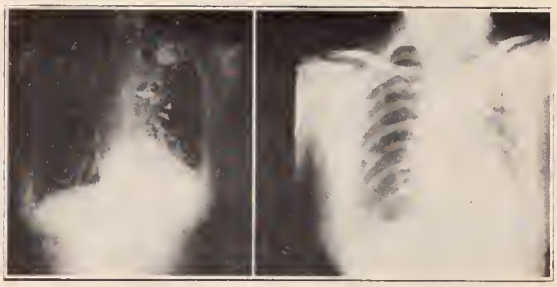

Fig. 14.—Bronchiectasis.

impairment and a medley of rales. Rales also were present at both bases. Cough was severe and expectoration profuse. Every morning on my desk in the laboratory would be a 4 ounce container of mucopurulent sputum and my report for ten successive days was a negative sputum.

In 1917 I joined the Army, and when I returned in 1918 the patient had been out and returned to the sanatorium. In fact, she had had five admissions, each after a hemorrhage. By this time we had expert laboratory technicians and from 1918 they repeatedly reported negative sputa by smear homogenized and by culture. Finally, lipiodol tests and bronchograms were performed, and the diagnosis of this case was upper lobe and basal bronchiectasis.

This patient was discharged as clinically nontuberculous with a diagnosis of bronchiectasis.

Conclusion

1. I would like to say that all of these patients had almost a specific history which I could not give in detail because of the length of my paper.

2. Every patient went through the scrutinizing process of differentiation.

3. The laboratory played a paramount part in clinching the diagnosis.

4. It is well to cite here that tuberculosis is not always easy to diagnose. Whereas the x-ray film is of the greatest help, there are many shadows and densities which are misleading. The fluoroscope also plays its part in defining certain lesions of the chest, heart included.

5. Many skin lesions have greater pathologic manifestations in the respiratory field than realized, which under the proper treatment of both, might prevent a fatal disease, particularly so in fungus infections.

432 Empire Bldg.

MARQUETTE MEDICAL SCHOOL OFFERS POSTGRADUATE COURSE IN OPHTHALMOLOGY

Marquette University School of Medicine on January 29–February 3, 1951, will present a postgraduate course in ophthalmology, designed particularly for medical doctors who have had some experience in refraction. However, if a doctor has had no practice in this field, the course may serve as an introduction to refraction, and added experience may be gained at home. Those taking the course will be required to obtain a schematic eye and a plane (not concave) mirror retinoscope. The fee for the course is $75.00.

The opening day will present a general introduction to the subject and a discussion on the anatomy and physiology of the eye. Accommodation, convergence, cycloplegics, and theory will be discussed as well as neutralize lenses. On Tuesday there will be an introduction to retinoscopy, with presentation of patients. Crossed eyes, amblyopia and instruments will also be subjects for discussion. The following day will be devoted to visual acuity tests, manifest refraction, cross cylinder fogging, etc., followed by talks on retinoscopy or manifest refraction, with presentation of patients. Further talks will be given on occupational refraction, bifocals, muscle examination, and external eye diseases. On Thursday morning patients will be used in a demonstration of manifest refraction, postcycloplegia, and retinoscopy. Use of prisms, fitting of glasses, pupillary distance, lens types and theory, and funduscopy will be other topics of discussion. Friday morning will open with a demonstration similar to that on Thursday morning, and the afternoon will be given over to talks on lens grinding and visual fields. The closing session, on Saturday morning, will cover fundus examination and practical recapitulation.

Inquiries concerning the presentation should be addressed to E. A. Bachhuber, M. D., Assistant Dean, Marquette University School of Medicine, 561 North Fifteenth Street, Milwaukee, Wisconsin.

"Base Coat" Nail Disease*

Report of a Case

By IRVING I. COWAN, M. D.
Milwaukee

I. I. COWAN

A diplomate of the American Board of Radiology, Doctor Cowan is in the private practice of radiology in Milwaukee. He is a graduate of Vanderbilt University School of Medicine, Nashville Tenn., and is assistant professor of radiology at Marquette University School of Medicine.

A NEW disease of the finger nails began to make its appearance in this country sometime in 1947. It followed the introduction in the commercial market of the "base coat" or "undercoat," a liquid substance that is applied to the finger nails before the polish or lacquer containing the pigment is put on. The purpose of the base coat is to make the polish or lacquer go on smoother, remain on for a longer period of time, and make it resist chipping off. The base coat is sold under various trade names** and all of these contain a solution of phenol-formaldehyde resins and synthetic rubbers in methyl, ethyl ketone. It is estimated that over 1,000,000 women have used these various base coats but only a few hundred cases of "base coat nail disease" have been observed in the United States and Canada. A survey of 234 dermatologists in the United States and Canada in May 1948 revealed about 274 cases of "base coat nail disease" seen. This report was made by Dr. James H. Mitchell[1] of the University of Illinois College of Medicine in Chicago. In 1948 Sulzberger[2] and his group in New York reported some of the earliest cases that were seen in this country.

Clinical Features

The changes produced in the nail are important because of the symptoms induced, that is, discomfort of the fingers, pain in the tips of the fingers, the unesthetic appearance of the nails, etc. In neglected or undiagnosed cases there is a possibility of complications developing, such as pustular paronychia, which may require surgical removal of the nail, as in one of the cases reported by Sulzberger and associates.

"Base coat nail disease" should be diagnosed without much difficulty. It has the following characteristic features. 1. It usually involves every nail to a varying degree, and the disease is rarely limited to one or two of the fingers, as seen in the fungus infections of the nail. It occurs in women with the average age of about 50 years. 2. It produces a discoloration of the nail varying from yellow through a reddish blue, to a brown and almost black color. The discoloration is usually diffuse but occasionally is punctate, and it involves the distal one third to two thirds of the nail (fig. 1). According to Mitchell, the earliest sign of the condition is the appearance of splinter hemorrhages in the nail bed, which will simulate the changes produced by a contusion except that in most instances all of the nails will have this appearance at one time. 3. There is a varying degree of separation of the nail from its bed. 4. Subungual hyperkeratosis is a very characteristic finding. It can be seen under the distal end of the nail and extends proximally under the nail. 5. In the late stages of the disease there is leukonychia (whitening of the nail) and also thinning of the nail in the distal one third. 6. The patient, if questioned, gives a history of having used a base coat or undercoat once a week or once every two weeks for several months before they noticed the changes in the nail. There is usually tenderness and pain in the finger tips, which will interfere with the normal use of the fingers, especially if the patient is engaged in any type of work requiring the accurate use of the fingers such as typing. Early changes of the appearance of the nail are missed by the patient because of the use of heavy pigments which cover up the abnormal state of the nail. Most women make a practice of reading while having a manicure and thus the disease goes on unnoticed until it gets to the advanced stages.

The differential diagnosis is based upon the presence of all the changes described plus certain laboratory findings. Infections of the nail with various types of fungi rarely involve all of the fingers. The scraping from the nail and the nail bed in fungus infections will reproduce positive findings on microscopic study of the smears and cultures.

According to Pardo-Castella,[3] in his monograph on "Disease of the Nails", the presence of subungual hyperkeratosis is a finding which accompanies other diseases of the nail and is most commonly seen in psoriasis or eczemas. In psoriasis usually there are

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

** Everon, Permanail, Adheron, Lustron, Stazon, Naylon, Chenyu, Duragloss, etc.

other typical psoriatic lesions in the skin which aid in differential diagnosis. Pardo–Castella described a type of generalized eczema of the skin which involves the nail. The chief difference between this type of eczema and the allergic reaction seen in "base coat nail disease" is as follows: In generalized eczema there is a diffuse involvement of the skin, which in some cases is complicated by nail involvement; the earliest manifestations are at the root of the nail and progress is made distally to the free edge of the nail. In "base coat nail disease," the skin is free from any changes except in the late stages, when paronychia may develop. The earliest changes are noted in the distal part of the nail, progressing toward the root. In both conditions there develop discoloration of the nail, separation of the nail from its bed, and subungual hyperkeratosis.

The most important and interesting change in "base coat nail disease" is the presence of capillary hemorrhages under the nail and a positive Rumple–Leeds test after tourniquet pressure in the cubital fossa. Capillary hemorrhages are demonstrated by means of the capillary microscope. These repeated capillary hemorrhages account for the discoloration of the nail, the pigmentation varying from red to reddish brown to black. In addition to the hemorrhages there is a change in the configuration of the capillaries in the nail beds and thecae as seen through the capillary microscope. As the disease advances a progressive thinning of the nail is noted and whitening of the distal portion. In the later stages, the nail has a tendency to separate itself from the bed in its distal portion. Scraped material from the nail and the nail bed shows no evidence of fungi on microscopic examination. The red blood cell count, the hemoglobin, the leukocyte count, and the differential counts are usually normal. Occasionally the sedimentation rate may be increased when the disease is in a very active phase.

Patch Tests

Patch tests using the single application without covering of any kind will produce, in almost every case, a positive reaction. The patch test is done with the type of base coat that the individual patient has been using and also with several of the other base coats that are marketed under different names commercially. The test may be done on the flexure surface of the forearm or on the skin of the back. The reaction is very slow in developing but remains positive for a long period of time. It may require ten days to two weeks before the reaction from the patch test becomes positive, and it may persist for six months or more. According to Mitchell, all of his patients who used the base coat showed positive patch tests. The patch tests were negative in those patients in whom the disease did not develop and on whom these specific base coats were used. The patients with positive tests had positive reactions to all of the base coats sold under the different trade names, indicating that these base coats had a common ingredient that was responsible for the reaction. These patch tests are a good evidence that the disease represents a form of allergic response. Biopsy studies of the tissue removed from the nail bed were done by Sulzberger and his group and revealed a typical allergic eczematoid type of reaction. The mechanism by which the base coat produces such a reaction is not clearly understood. It is assumed that the specific chemical substance or allergen penetrates through the nail after its application on its surface. Some of the base coat material may seep under the distal end of the nail because of the localized changes, such as hyperkeratosis, that develop only in this area. Capillary hemorrhages, which account for the discoloration of the nail and the change in configuration of the capillary bed, are the early manisfestations of the disease. Later, as the allergic eczematoid reaction continues, the nail becomes thin and separates from the bed, and the subungual hyperkeratosis develops.

Chemical Analysis

Chemical analysis of the various base coats indicates that all of the preparations contain phenol in approximately 1 per cent solution, plus formaldehyde, which together form a resin. A synthetic rubber solution is also found in all of the manufactured base coats. The patch tests with the breakdown products of the base coat are usually equivocal, but with the specific product itself the patch test is almost always positive in patients showing clinical evidence of the disease and also in sensitive individuals without evidence of the disease. I wish to emphasize that not all base coats on the market at the present time contain a solution of synthetic rubber and phenol-formaldehyde type of resin in methyl ethyl ketone. There have been products for sale as an undercoat or polish, which contain a nitrocellulose solution which does not produce the type of allergic reaction in the nail as described in this report.

Treatment

Treatment of the disease is complete discontinuance of all applications to the nail. The use of any kind of nail polish, pigments, etc., should be prohibited. There will be a spontaneous involution and return to a normal state in appearance of the nail within three to six months. This is further proof that the condition is due to an allergic reaction to some substance contained in the base or undercoat applied to the nail.

Report of a Case

Miss S. G., age 34, stenographer by profession, was first seen on July 22, 1948. She complained of discoloration of the nails and tenderness of the finger tips which interfered with her ability to type. She first noticed the abnormal color in the nails about three weeks prior to the examination. The pain in the fingers had become worse in the preced-

ing three weeks, and she could not continue at her work. This patient was referred for x-ray therapy with a clinical diagnosis of a fungus infection of the finger nails.

Local examination revealed the following: All of the finger nails were involved to a greater or lesser degree. The distal one third to two thirds of the nails were discolored, and the color varied from dark red to a reddish black. There was thinning of the nail with separation of the distal part of the nail from the bed. Very marked subungual hyperkeratosis was noted in all of the fingers. There was tenderness on pressure over the finger tips, which were slightly edematous. No paronychia was seen. There was no evidence of any eczema of the skin or any other changes in the dermis. The general physical examination was negative.

Fig. 1.—Photograph showing typical changes in the nails in case of "base coat" nail disease (photograph courtesy of Dr. Bernhard Yaffe).

On further questioning, the patient stated that for the past three months her manicurist had been using a base coat application before applying the lacquer containing the pigment. The base coat was sold under the name of Everon* and was applied regularly every two weeks. The patch tests were applied to the left forearm on June 28, 1948, using the material that was obtained from the manicurist. Sixteen days after the test the Everon application showed a definite positive erythema, with elevation and edema of the skin. Tests done at the same time using an alcohol and an oil solution gave negative reactions. Later patch tests were done with other makes of base coat material, as "Naylon," "Stayon," and "Perma Nail," and all of these elicited positive. reactions. Scrapings from the nail and the nail bed were negative for fungus.

The laboratory findings are as follows: hemoglobin 14 Gm., red blood cells 4,090,000, white blood cells 8,300, and platelets 230,000. The differential count was as follows: polymorphonuclears 56 per cent, lymphocytes 42 per cent, and monocytes 2 per cent. The sedimentation rate in 15 minutes was 1 mm.; 30 minutes, 5 mm.; 45 minutes, 11 mm., and 60 minutes, 17 mm. The volume of packed cells was 41, coagulation time 15 minutes and clot retraction normal. There was a positive Rumpel–Leeds test with tourniquet pressure in the cubital fossa. Capillary microscopy, done by Dr. Carol Birch of the University of Illinois College of Medicine, revealed the following: "Each nail was divided into two parts by a sharp line of demarcation. Distal to these lines the nails were separated from their beds. Proximal to these lines, there were long dense, old flame-shaped hemorrhages extending parallel to the long axis of the nails. Some of these were microscopic. Near the bases of the nails there were a few small fresh microscopic hemorrhages. The capillaries of the thecae were dilated with complicated loops and figures of eight, bowknots, and extensive networks. There were no hemorrhages in the thecae."

The patient was advised to abstain from the use of any type of applications to the nails, and she was re-examined after three months, at which time the pigment changes of the nail had almost completely disappeared. There was still a slight ridging of the nail and a few punctate areas of discoloration. The nails were no longer separated from the nail beds and the subungual hyperkeratosis had regressed, with a few very small residual growths. Six months later the nail beds had returned to a normal state in their gross appearance.

Conclusions

1. "Base coat nail disease" was first observed in 1947 after the introduction on the market of a liquid substance known as a base coat, or undercoat, which contained a solution of synthetic rubber and phenol-formaldehyde type of resin in methyl ethyl ketone. Only those base coats containing this solution will produce the clinical condition described in this report. The solution is applied to the nails in order to preserve and protect the lacquer containing the pigments.

2. The disease is important from the clinical standpoint because it can produce symptoms. Serious complications, such as pustular paronychia, requiring the removal of the nail, may occur.

3. The disease presents a very characteristic picture as follows: (1) usually involvement of all the nails; (2) definite discoloration of the nails in their one third to two thirds; (3) thinning of the nail with onycholysis or separation of the nail plate; (4) leukonychia, or whitening of the distal end of the nail; (5) capillary hemorrhages in the nail bed and the presence of subungunal hyperkeratosis (The Rumple–Leeds test with the tourniquet over the cubital fossa is usually positive); and (6) positive reactions to patch tests with the base coat solution in 10 to 14 days in all individuals in whom the disease develops.

* Revlon Products Corporation, Manufacturer and Distributor.

4. A detailed case report is given to illustrate the characteristic history and findings.

5. This disease is most usually mistaken for the fungus infection, but scraping of the nail and the nail beds submitted for microscopic study and cultures are negative for fungi.

6. This disease is thought to be a definite allergic reaction to an unknown substance in the base coat preparation.

7. The treatment is simply the elimination of the offending agent, and there will usually be spontaneous recovery within a period of three to six months.

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UNIVERSITY OF MINNESOTA SCHEDULES CONTINUATION COURSES

The University of Minnesota announces a continuation course in clinical chemistry for internists, pediatricians, and general physicians on December 7–9, 1950. Dr. John T. Merrill of Boston, Massachusetts, will be the visiting faculty member for the course

A continuation course in geriatrics for internists and general physicians will be given on January 4–6. Distinguished visiting physicians who will participate as faculty members for the course include Dr. E. V. Cowdry, St. Louis, Missouri; Dr. William Dock, Brooklyn, New York; Dr. Nathan Shock, Bethesda, Maryland; Dr. E. J. Stieglitz, Washington, D.C.; and Dr. E. L. Tuohy, Duluth, Minnesota.

A continuation course in obstetrics will be presented at the University of Minnesota on December 15 and 16. The course is intended for general physicians. Visiting faculty members for the course will include Dr. Emil G. Holmstrom, University of Utah Medical School, Salt Lake City, Utah; Dr. Curtis J. Lund, Louisiana State University Medical School, New Orleans, Louisiana; and Dr. Charles E. McLennan, Stanford University Medical School, San Francisco, California.

Distinguished physicians who will participate as faculty members in a continuation course in clinical neurology to be presented by the University of Minnesota at the Center for Continuation Study from January 29 to February 10, 1951, are as follows: Dr. Pearce Bailey, Georgetown University School of Medicine, Washington, D. C.; Dr. H. W. Magoun, University of California Medical School; Dr. Henry Schwartz, Washington University School of Medicine, St. Louis; and Dr. S. Bernard Wortis, New York University Medical Center. Dr. Magoun will also deliver the annual J. B. Johnston lecture on the subject, "Wakefulness and Sleep."

Carcinoma In Aberrant Breast Tissue

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ABERRANT breast tissue is an anomaly which has neither nipple nor areola. It must be differentiated from supernumerary or accessory breasts which have either nipple or areola (or both) in combination with gland tissue. The reason for this distinction will be brought out in the discussion of tumor formation in these abnormal breasts. The terms aberrant, accessory, supernumerary, and excess breasts have been used indiscriminately and confusingly. Anomalies of the breast are attributable to a deviation of ontogenetic differentiation. From the practical point of view, supernumerary breasts along the axillocrural milk line and aberrant breasts are distinguished, the latter constituted by a mammary lobe in abnormal position but within the pectoral region. The purpose of this paper is to review the literature on the subject, to discuss it, and to present a case. The case is unusual in that the aberrant breast tissue was located over the sternum, that there has been a six year survival, and that the lesion has metastasized and is superimposed on previously existing Paget's disease of the spine.

Aberrant breast tissue is seen relatively frequently. It occurs in proximity to the normal breast, most often in the axilla, but it is also found in the clavicular and sternal regions. The masses are often first noticed during pregnancy. Matti [1] observed that scattered segments of mammary glands (i.e., aberrant tissue) show a considerably higher tendency toward malignancy, whereas supernumerary mammary glands apparently are not more frequently involved in tumor formation than the normal glands. Razemon and Bizard [2] collected all cases of aberrant mammary tumors reported up to 1929, a total of 76 observations. Of 43 malignant tumors, 28 were axillary, 10 sternal, and 5 subclavicular. Only one was in a male. They noted that pre-existing connections with the breast itself were rare, but secondary connections were common, either by continuity or in the form of two independent tumors. The corresponding breast was often invaded, although the tumor might relapse in the apparently normal breast. The axillary lymph glands were rapidly invaded, and metastases in the contralateral axilla were seen. Ultimate results were available in only 19 cases. Out of 13 patients operated upon with preservation of the breast, 10 had relapses, seven of these being in the breast, six weeks to two years after operation. The other 3 were not observed long enough to be conclusive. Four patients had complete operation (i.e., radical mastectomy), but the results were not any more encouraging. One died of "pulmonary generalization" in three months, 1 showed mediastinal recurrence after a year, 1 died after 19 months from multiple metastases, and 1 had been followed for only five months. In the 2 remaining cases, the surgical reports are incomplete, but both had relapses.

Giacobbe [3] added 1 case in 1930. This patient had an axillary tumor the size of an orange and palpable glands in the axilla and above and below the clavicle. The outcome following radical excision was not recorded. Biancheri [4] in 1932 reported the "thirty-first case of cancer of an aberrant axillary mammary node." Apparently he disagreed with the earlier tabulations and considered some of the cases unproved. As this tumor was located 4 fingerbreadths from the breast, intervention was limited to evacuation of the axilla. This was followed by radiotherapy. Two years later the patient succumbed to mediastinal, pleural, and pulmonary metastases.

Massabuau, Guibal, and Guibert [5] of Paris reported 3 cases of cancer in aberrant lobes which they saw within a few months. All three tumors were situated on the left side; one was axillary, one subclavicular, and one juxtasternal. Clinically, these tumors presented all the findings of true cancer of the mammary gland. The authors found, however, that there was an absence of retraction or displacement of the nipple and independence from the gland. Also, the tumors were more superficially located and showed a tendency to early adherence to the skin and early ulceration. No end results were given.

Erdmann [6] presented his experiences in 1,054 breast operations performed over a period of almost 30 years (1905–1934). He found 573 breast carcinomas of all varieties. He reported seven aberrant breasts in the entire series. The last three he saw were all highly malignant, one being in a man of 26. Of the 2 women, 1 lived for four years before bony metastases developed, chiefly in the pelvis and thigh. The other lived for "several years."

Ravdin [7] presented in 1934 a case of carcinoma arising in a subclavicular accessory mammary tissue. The small hard nodule was excised and found

to be adenocarcinoma in aberrant breast tissue. Intensive deep therapy was employed, but the lesion recurred locally within six months. Then the breast was removed, the axilla dissected, and the local lesion widely excised. No malignancy was found in the breast, although there was recurrent carcinoma at the site of previous local excision. Schmidt–Tannwald[8] observed aberrant breast tissue the "size of a man's palm" beneath the clavicle of a woman.

A case in which an incorrect diagnosis had first been made was reported by Matti.[1] The patient was thought to have tuberculosis of the lymph glands, but biopsy finally revealed carcinoma. Following intense roentgen therapy, the axillary tumor was removed. One month later a gland was palpable. More roentgen therapy was instituted, but in six weeks there was a firm infiltration in the lateral portion of the breast on the same side. A radical mastectomy was performed and another carcinomatous lesion was found.

In his series of 41 cases of aberrant breast tissue, de Cholnoky[9] reported that all of the patients were women and all with the tissue in the axillae. Only 11 of his patients were treated surgically, and in these the character of the tissue was proved by pathologic examination. No malignancies were recorded in this series, which is not in accord with the findings of other authors. Cole[10] states that the treatment of aberrant breast is of much more importance (than treatment of an accessory breast), chiefly because of the frequency of development of cancer in the former lesion.

Three cases of carcinoma of the type usually found in breast tissue, but not definitely located in the breast itself, were presented by Rawls.[11] In 2 of the cases in which a complete operation was done, no evidence of tumor was found in the breast itself. Franceschini[12] added another case. His patient was a woman of 64 who had noticed a subclavicular nodule present since childhood, which increased in size during each of her pregnancies. It suddenly enlarged when she was 63, and radical intervention was carried out a year later.

Undoubtedly the most authoritative and extensive writing on the subject is by Geschickter[13] in his book, "Diseases of the Breast." In his series there were 7 cases of cancer in aberrant breast tissue. In all of them, the condition occurred in the axillae of women. The youngest patient was 39 and the oldest 67 years. The duration of symptoms ranged from six weeks to two years. The chief complaints were swelling, tenderness, and pain or discomfort in using the arm. The tumors varied from 2 to 8 cm. in diameter. Initial treatment in 4 of the patients was simple excision. This was followed by irradiation in 2 patients who refused radical surgical procedures. In the other patients radical mastectomy was performed, with dissection of the axilla, but in one instance not until the tumor recurred. The 4 adequately followed died from the disease, 1 slightly beyond the five year period, the others within a period of about one year. Strangely enough, the 1 patient that survived the longest, had had only simple excision of the tumor followed by irradiation. (This should be borne in mind when the author's case is presented.) Geschickter's cases were classified pathologically as 3 of infiltrating scirrhous cancer, 3 of medullary or neomammary cancer, and 1 of adenocarcinoma or sweat gland cancer. In all of the patients who submitted to complete operation, the tumor had infiltrated the axilla, but the breast was normal.

Report of a Case

The case of carcinoma in aberrant breast tissue being reported is of particular interest because of the location of the original tumor, the prolonged freedom from involvement of either breast itself, the length of survival, and the ultimate metastases being superimposed on previously existing Paget's disease in the spine.

The patient, Mrs. A. S., was first seen in May 1944. At that time she was 59 years of age. Her chief complaint was of a "lump between the breasts." She stated that she had first noticed a small tumor over the "breast bone" several months before. It had increased gradually in size and had become red. It was very painful. She was otherwise well, and only the pertinent positive items in her inventory by systems and past history will be recorded. She had worn glasses for many years. Her weight was constant. There were no symptoms referable to the cardiovascular, gastrointestinal, or genitourinary systems. She had had the usual childhood diseases, and an appendectomy and oophorectomy had been performed in 1919. In 1931 she injured both knees in an auto accident, resulting in a limp. She had been married 32 years, had never been pregnant, and had always lived on a farm in southern Wisconsin.

Physical examination revealed a well developed, well nourished white female, not acutely ill with a temperature of 98.6 F. The pulse rate was 78 and perfectly regular. Her blood pressure was 140/80. The eyes, ears, nose, and throat were not remarkable. The frontal bosses of the head appeared prominent. The chest was clear. The heart rhythm was regular, there were no murmurs noted, and there was no enlargement. The breasts were large and pendulous. Squarely between the breasts on the midline over the sternum there was a hard, fixed, tender nodule about 1 cm. in diameter. The skin over the nodule was inflamed. Careful palpation of both breasts did not show any other nodules, nor were there any palpable nodes in either axilla. Examination of the abdomen revealed nothing of note; neither did the nulliparous pelvis. The patient did walk with a marked limp, caused by an apparent shortening of the right leg.

Roentgenogram of the chest was negative for metastases. Serology was negative. Routine urinalysis, blood cell count, and blood chemistry were all within normal limits.

Fig. 1.—Photograph showing site of original tumor over sternum and telangiectasis resulting from x-ray therapy.

The patient was admitted to the Edgerton Memorial Hospital on May 8, 1944. The following day the tumor overlying the midportion of the sternum was widely excised with the patient under a general anesthetic. Excision was made down to the sternum itself. The breasts and axillae were not operated on, as no connection between them and the tumor was ascertained.

Pathologic Report (M. B. Llewellyn, M.D.).—A section of the tissue showed one surface to be covered by epidermis which was well differentiated and intact. Infiltrating the corium and subcutaneous tissue were small masses and columns of atypical epithelial cells showing little glandular differentiation. Especially in the deeper portion, the infiltrating epithelial masses were separated by abundant dense fibrous tissue. Striated muscle was also infiltrated by similar neoplastic tissue. The appearance was characteristic of a scirrhous carcinoma of the breast, although no breast lobules were present in this section. The slide was reviewed by Doctors Bunting and Stovall at the University of Wisconsin. Both considered it a true adenocarcinoma of aberrant breast tissue. The patient's convalescence was uneventful, and intensive x-ray therapy was begun at Wisconsin General Hospital on the eighth postoperative day. She received ten treatments of 310 roentgens each over the anterior middle chest.

For the next three and one half years the patient was seen at regular intervals. Chest x-rays in February and November 1947 revealed no change. However, late in the summer of 1947 she noted soreness and a mass in each axilla. She came in again in November 1947. Examination of the chest and both breasts was negative. There was no local recurrence over the sternum, but there was a fixed mass in each axilla. On the right it was attached to the skin, while on the left it was deeply adherent. Her weight had remained constant, and laboratory findings were within normal limits. She was again admitted to the hospital, and on Nov. 15, 1947 a dissection of both axillae was performed with the patient under general anesthetic. On both sides there were masses of densely adherent hard tissue with many shotty nodes extending in chains in all directions.

Pathologic Report (M. B. Llewellyn, M.D.)—A section of the smaller piece of tissue showed it to be covered by skin. The deeper corium and subcutaneous tissue were infiltrated with small dark-staining epithelial cells which occurred singly or in small columns and alveolar masses. A section of the larger piece of tissue showed the central portion to be composed of dense hyaline connective tissue containing a few very thick-walled blood vessels and the peripheral portion to be composed of fat. Distributed throughout, but more numerous in the peripheral portion of the fibrous connective tissue and adjacent fat, were cords of small atypical epithelial cells. The walls of the blood vessels showed infiltration with neoplastic epithelial cells. Although there was some lymphocytic infiltration about the growing margin of the tumor there was no recognizable lymph node structure. All of the sections showed a scirrhous type of adenocarcinoma. Although there were no breast lobules seen in the sections, the appearance was typical of a carcinoma arising in the breast. No lymphoid tissue was recognizable in the sections from the axilla, so that it was impossible to state that the tumor seen was metastastic in lymph nodes. However, it is possible for a tumor to completely replace a lymph node. The conclusion was that her condition was scirrhous carcinoma, probably primary in the breast.

On the eighth postoperative day the patient was discharged from the hospital, and a week later reported to Wisconsin General Hospital for more x-ray therapy. This time she received 2,500 roentgens to each axilla, in ten doses of 250 roentgens each.

About a year later the patient was found to have multiple recurrences. There was a single small node at the lower end of the original midsternal incision. There was also one small node in the upper outer quadrant of the right breast, and there were many hard nodes in the right axilla, all densely adherent both to the skin and deep tissue. X-ray of the chest was still negative for metastases in January 1949. On Jan. 21, 1949 the patient again submitted to surgical treatment. The two solitary nodes were excised, and the right axilla was again cleaned out as thoroughly as possible. This was difficult because of the dense adhesions following the previous operation and irradiation. The pathologic report was the same as before, there being no evidence of lymph node structure in the sections. The patient was discharged in nine days, declining further x-ray therapy.

In May 1949, the patient was hospitalized for pneumonitis. Her red blood cell count, hemoglobin, and weight remained constant. Her skull was obviously larger. Unfortunately, the metastatic process continued relentlessly. By August 1949, both axillae were again studded with nodes. On August 8 the axillae were dissected once again, and multiple matted, densely adherent nodes were excised. Microscopically, they were the same as before. Healing was slower this time, and serosanguineous drainage

persisted for over two weeks. A chest x-ray revealed some changes in the ninth and tenth dorsal vertebrae. Further x-ray studies of the dorsal spine, skull, and pelvis revealed the following: An extreme degree of thickening of all the cranial bones, measuring up to 3.5 cm. over the vertex, and mottled islands of sclerosis and intermixed areas of rarefaction; a thickening of the pelvic bones with widely involved sclerosis and intermixed cystic appearing areas; a varus deformity of the right femur and intrapelvic protrusion of the acetabulae, more marked on the right; the same type of lesions on the heads and necks and shafts of the femurs as seen in the pelvic bones; and beginning malignant degeneration in the ninth and tenth dorsal vertebrae on the basis of pre-existing Paget's disease. In view of these findings, the patient received six doses of 200 roentgens each of irradiation over the lower dorsal spine. X-ray examination of the spine was done again in December 1949, and no change was seen in the affected vertebrae.

After almost six years, it now appears that we are fighting a losing battle with this patient's neoplasm. In January 1950, she was found to have a very tender node in the upper, outer area of the left breast (the first ever to be found in that breast), larger than any single node previously seen. There was also a chain of nodes traversing the right axilla. In view of the vertebral metastases, further surgical procedures seem futile. The patient refused more x-ray therapy. That rather narrowed down the field of treatment. There has been much written about the use of testosterone in the treatment of female breast carcinoma. In the extensive literature on the subject, nothing could be found in regard to its use in carcinoma in aberrant breast tissue, but there is no reason why it should not be as effective as in other breast carcinoma. Consequently, the patient is now receiving 50 mg. of testosterone proprionate in oil intramuscularly three times a week. This treatment has not been continued long enough to evaluate it, but there has been no adverse effect.

Summary

A case of carcinoma in aberrant breast tissue located over the sternum has been presented. Initial treatment consisted of local excision followed by x-ray therapy. Metastatic lesions occurred simultaneously in both axillae three and one half years later. The first small lesion to be found in the breast itself was seen four and one half years after the original tumor. At five and one half years a lesion appeared in the opposite breast. There has been a running battle to try to keep ahead of the patient's metastases. Malignant changes have been found in vertebral bodies, superimposed on a pre-existing Paget's disease. Having exhausted the possibilities for surgical treatment and x-ray therapy, the patient has recently been started on testosterone injections. Thus far, the patient has survived almost six years since her first surgical intervention, somewhat longer than any patient previously reported.

Conclusions

1. Aberrant breast tissue is seen relatively frequently.

2. Malignant degeneration occurs more often in aberrant breast tissue than in supernumerary or normal breasts.

3. Most aberrant breast tissue is axillary in location; rarely it occurs in sternal or subclavicular areas.

4. Aberrant breast tissue is rare in the male.

5. The corresponding breast is frequently invaded when there is carcinoma in aberrant breast tissue.

6. Axillary lymph glands are rapidly invaded.

7. The results have been uniformly bad, as metastases and death have been reported in from a few months to five years in all cases that were followed.

8. The extent of surgical intervention seems to have little bearing on the outcome. Although all authors recommend radical mastectomy, the 2 patients that have survived over five years had only simple excision followed by irradiation (Geschickter's silghtly over five and ours almost six years).

Addendum

Several months have elapsed since this article was submitted for publication. The patient now has survived six and one-half years since her initial operation. Immediately following the initiation of the testosterone therapy, she reported a weight gain of 15 pounds and a marked improvement in her sense of well-being.

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The Incidence and Management of Eczema in the First Year of Life*

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IN ALL diseases there are varying degrees of susceptibility and exposure and, therefore, states of equilibrium in which the host shows only minor evidences of the disease. It must certainly be the case in eczema, as in other diseases, that rudimentary or subclinical forms occur in large numbers without typical manifestations. These mild examples are not usually seen in a hospital or clinic. They are seen quite frequently in any pediatric practice. This fact, plus the additional observation that the eczemas seen among those infants who come in for regular checkup are rarely as severe as those seen in hospital work, prompted me to examine my office records as to the validity of these two points. A review of the incidence and character of eczema among 1,000 infants seen in routine pediatric practice indicates that the severe intractable eczema is the exception in a disease in which the norm is quite amenable to treatment.

It used to be said that eczema was a "forty weeks disease." Review of any pediatric clientele will reveal the fact that the majority of infant eczemas respond readily to treatment in the course of a few weeks that that a relatively small number become chronic, recurrent, and intractable. This does not in any way invalidate Hill's statement that "infantile eczema is a perplexing and exasperating disease to treat."[1] As Hill is an outstanding student of childhood allergy, who sees many referred cases, the conditions in his cases would obviously be more severe than those in the average experience.

It is generally accepted that the character of eczema depends on the frequency and degree of exposure to numerous environmental influences of a specific and nonspecific character and to the intensity of the genetic idiosyncrasy.

The pediatrist or general practitioner who sees his patients at monthly intervals and gives advice concerning them in between times over the phone has it in his power to do a great deal with the infant's total environmental experience and thereby influence the reactive mechanisms of the eczema infant.

Since there are no absolute criteria for the diagnosis of eczema, any selected group of cases lends itself to criticism. Not every eczema seen in infancy parades in the orderly evolution from erythema to crusting. Some skip one phase or another, either as a result of treatment or as a result of immunity mechanisms still unknown to us. The dilemma of diagnosis is an old one in eczema and is inferred in the oft-quoted definition of Hebra, adopted by Neisser: "Wir dasjenige Ekzem nennen, was unter dieser Krankheitsform auftritt"—"What acts like eczema, we call eczema."[2] Obviously, the present series does not include frank cases of diaper rash, heat rash, chafing, contact dermatitis from drooling, etc. It does include seborrheic eczema, differentiation of which seems difficult in the infant in whom "the vascular and urticarial reaction of atopic dermatitis and the inflammatory edema of seborrheic dermatitis" may equally "lead to vesiculation, weeping, and crusting."[3] In successive cases which look like the "spit and image" of each other, one may respond to an antiseborrheic remedy, while another may not, and may soon take on the characteristics of a typical atopic dermatitis. The difficulty is further complicated when the subsequent history of the supposedly seborrheic child parallels that of a truly allergic subject.

Among 1,000 infants seen for monthly checkup in the home or office, there were 295 cases of eczema. Of these 241 responded readily to the first set of instructions. In many instances this was no more than a prescription for local therapy. These 241 had no recurrence of eczema during their first year. There were 53 who had recurrences during the first year, necessitating further treatment. Of these, 45 again responded to treatment in the course of a few days or weeks. Eight remained resistant throughout the first year of life.

The main justification for this paper is to emphasize what seems to me of basic importance: Since the pediatrist or general practitioner first sees the infant, he is the one who must prescribe treatment. In this treatment, he must take into consideration all possible etiologic factors (fig. 1); he must begin it at the first appearance of the rash, and he must modify or renew it with every change in the skin condition. This therapy does not call for any elaborate technics. It may be reduced to the simple terms of an instruction sheet, as follows:

Instructions For Infantile Eczema

1. Avoid scratching. Use arm splints on baby day and night.

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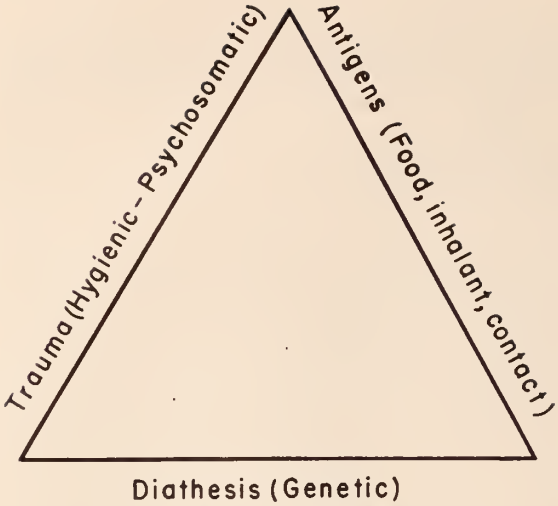

Fig. 1.—Etiologic factors in infantile eczema.

2. Avoid wool next to baby. This applies to clothing and blankets, which should not come in direct contact with the baby's skin.
3. Always place cotton cloth under baby when laying him on upholstered furniture.
4. Avoid keeping baby too warm. (Room temperature 68 F.) The skin will be better if kept cool; a minimum of clothing is desirable.
5. Avoid pillows. These are too heating. Keep the baby in a large size bed, not in a small crib.
6. Avoid house dusting in presence of the baby.
7. For bath use bran or tar bath as directed. Wash baby's buttocks with boric acid solution at every diaper change.
8. Follow diet instructions.
9. Use skin prescriptions as directed.
10. Use tablets if baby is fussy. These will lessen the itching.

At the time of the physician's first visit, he should discuss the various items of therapy with the mother. He should call her attention to the fundamental characteristic of the eczema which the infant has, towards which all treatment is directed. That characteristic is the heightened sensitiveness of the eczema skin to trauma of all kinds. A useful illustration for the intelligent mother may be taken from Bloch,[4] who showed that, whereas 5 per cent of normal persons reacted to a group of test substances, 35 per cent of patients with eczema reacted.

Discussion of Instructions

One cannot emphasize too strongly the important part scratching plays in preventing healing and in aggravating the severity of infantile eczema. A minute of unguarded scratching will undo all that has been gained in a week's treatment. A good deal of the advantage gained by hospitalization of patients with severe eczemas may be credited to the success of restraints. It is well to give the mother a pair of the usual arm guards (tongue blades encased in muslin wrapping) at the time of the visit. Unless the splints are readily available, advice to use them is often disregarded.

The average home, with its overstuffed furniture, carpets, and curtains, is an invitation to decay and dust. The infant's skin should be guarded in as practical a way as possible from these as well as from direct contact with dye stuffs of textiles, and from all those items which accumulate in what Ratner has called "the collector's room."[5] Because of the possible effect of inhalants on the skin, the physician should specifically call attention to house dusting. Even on a cold day, the infant with eczema is safer outdoors than taking part in the vacuuming.

Diet Instructions

The only dependable way of deciding whether particular foods have etiologic significance is by trying the foods one at a time. The infant's diet is sufficiently restricted in content to lend itself to such experiment without the tedious and questionable technics of skin testing. I know of no diagnostic technic less rewarding than skin testing in eczema infants. Hill[1] boldly states: "It is as natural a phenomenon for an atopic person to have positive reactions as for a fish to have scales. It is part of his makeup. That is the way he reacts to absorbed food proteins, it is a mark of his constitution, but comparatively few of these reactions have anything to do with his allergic symptoms."

Cooke's comment[6] is more emphatic: "Intradermal or scratch tests must be discarded as diagnostic procedures in eczema."

Every pediatrist will find in his records what I find in mine. In no single disease have there been as many divergent diets tried: high fat, low fat, low sugar, acidification, fruit and vegetables without milk, milk substitutes of all kinds, etc. Occasional patients will respond to any one of these diets in which there is no apparent common factor, or to diets dictated by the results of scratch or intracutaneous tests.

In his first 12 months, any infant can get along temporarily on a very few foods. Most of my patients with eczema are given evaporated milk, with the occasional added precaution of boiling the unopened can for 15 or more minutes before making the formula. (Mothers should be warned to wait until milk cools before opening can!) Whenever there is an associated gastrointestinal problem, lactic acid milk is used. Occasionally a milk substitute such as Mull Soy, Nutramigen, or the Rowe-Glaser milk substitute is used.[7] Synthetic vitamins D and C are prescribed.

After a week or two, oat, barley, or rice cereal, sieved apple, peaches, pears, and bananas are added to the diet.

The mother who cannot resist feeding tidbits from the family table to the baby is particularly warned against egg, wheat, orange, tomato, potato, fish, chocolate, peanut butter, spinach, chicken, fish

oils, because of the part played by these foods in many allergic people as allergenic primers.

It is well not to overfeed the fat, nor underfeed the skinny infant.

Dermatologic Therapy

The stage of the eczema process determines the kind of prescription: wet dressings for moist eczemas, soothing ointments or oils for the intermediate, and tar for the later stages. Unless one has the versatility of a Sulzberger[3] or Epstein,[8] it is well to stick to a few prescriptions which have stood in good stead. There is a great temptation to overtreat. Most frequently used in my series were 5 to 10 per cent Burow's Solution (or Domeboro tablets—1 to a pint of water) for the wet stage; zinc oxide and olive oil or Lassar's paste without salicylic for the erythematous stage; and tar for the dry stages (Tarbonis, containing 5 per cent liquid carbonis detergens; or Dr. J. C. White's original prescription, which is crude coal tar and zinc oxide, 2 parts of each, and petrolatum, as much as will suffice to 30 parts, or Mazon, which contains tar, salicylic acid, and mercury.) Feer's prescription has proved useful in subacute varieties with itching (Naftalan and lanolin, 25 parts of each, boric acid 5 parts, and zinc oxide 10 parts). Kreibich's list of 150 or more medicaments in his "Handbuch der Haut and Geschlechts Krankheiten" is an indication that experts have been stumped.[9] Since the ordinary soaps may irritate the skin of an eczematous infant, a soap substitute may be tried (Lowilla, Acidolate, or Phisoderm.) These do not seem, of themselves, to play any great part in the results of therapy of my cases. It is important to avoid plain water baths, substituting mineral or olive oil, starch, bran, or tar, according to the condition of the skin.

Phenobarbital, 1/8 grain several times a day, helps allay the itching and prevents the fussiness which causes scratching with its associated damaging effects. I have yet to encounter any harm from phenobarbital given for this purpose during the acute phases of an eczema. What is more important than sensitization to phenobarbital is the realization that some babies may be stimulated instead of quieted by the drug. For these cases, other barbiturates may or may not prove helpful.

The restlessness and fussiness of a baby with eczema does not enhance the peace of mind of the mother. The psychosomatic interplay that ensues often poses problems as resistant as the infant's skin. These problems must be given consideration by the pediatrist or be referred to those who will give them consideration.

To soothe the baby's skin and the family's frayed nerves at the same time, temporary hospitalization may be the answer. The introduction of antibiotics and a greater resourcefulness in the use of intravenous electrolyte therapy has almost eliminated the hazards formerly experienced with hospitalized eczema infants. Since, in my series of cases, I had the advantage of early diagnosis and direction, an advantage I can not emphasize too strongly, no hospitalization was necessary.

Summary

Intractable eczema is the exception in a disease in which the norm is amenable to treatment. Eczemas among those infants seen for monthly check-ups are never as severe as those seen in hospital wards or outpatient clinics. Among 1,000 infants seen for monthly check-ups from birth to 12 months of age, there were 295 cases of eczema, in only 8 of which the condition remained obstinate beyond this age.

The pediatrist or general practitioner is in a key position to control the infant's total environmental experience, thus influencing the severity of skin manifestations.

All infants should be guarded against trauma-producing elements. The eczema infant must be particularly guarded against these, whether they are of an allergic character or are mechanical irritants.

Diets for the eczema infant may be written without recourse to the questionable evidence of skin tests.

A simple and effective plan of treatment for infantile eczema is outlined.

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PAN-PACIFIC SURGICAL ASSOCIATION TO MEET IN HAWAII

The Fifth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, November 10–21, 1951. The congress provides an opportunity for doctors to combine a vacation with attendance at a scientific meeting, the program of which will be presented by topflight surgeons from the Pacific area countries.

Further information may be obtained by writing the Pan-Pacific Surgical Association, Suite 7, Young Building, Honolulu, Territory of Hawaii.

Carcinoma of the Jejunum

Report of a Case

By W. T. CASPER, M. D. and V. L. BAKER, M. D.
Milwaukee

W. T. CASPER

A graduate of Northwestern University Medical School, Doctor Casper interned at St. Joseph's Hospital in Milwaukee and trained in surgery at the University of Pennsylvania Graduate School of Medicine and at St. Joseph's Hospital. During World War II he served in the United States Navy. At present he is a member of the surgical staff of St. Joseph's Hospital in Milwaukee.

V. L. BAKER

Doctor Baker, a graduate of Marquette University School of Medicine, is a member of the staff of St. Joseph's Hospital, Milwaukee. Following internship at St. Joseph's Hospital, he served with the United States Navy for four years during World War II. He is a member of the American Academy of General Practice.

THE striking similarity of symptoms in cases of carcinoma of the jejunum reported in the literature suggests that the number of patients treated reasonably early might well be increased. The usual long period of time between onset of symptoms and discovery of the lesion is probably a major factor in the extremely poor prognosis accompanying it. A recent case, which is herewith reported, is so typical in retrospect that it serves to emphasize the diagnostic criteria which should aid in the earlier recognition of this condition.

Carcinoma of the jejunum is of great interest to the surgeon because of its reputed infrequency of occurrence, its difficulty of diagnosis, the high mortality its treatment entails, and its poor prognosis. A great deal of confusion exists in the literature relative to its frequency, partially due to failure to statistically differentiate between carcinoma and other malignant lesions, and partially to the fact that conclusions have necessarily been drawn from small series of cases. Because of diagnostic difficulties, these cases tend to gravitate toward large clinics, and they, accordingly, report more frequent occurrence of this lesion than do smaller hospitals throughout the country. Mayo and Nettrour[1] reported a series of 31 cases from 1907 to 1937, and they stated that their incidence of carcinoma of the jejunum was 0.15 per cent of all of their cases of gastrointestinal cancer. The Lahey clinic has discovered 12 cases in 30 years.[2] In contrast to these figures from two of the country's largest clinics, this present case is the only one found in 172,263 hospital admissions in our general hospital over a period of 20 years. During this time there have been 1,255 cases of carcinoma of the gastrointestinal tract. This coincides with the experience of St. Luke's Hospital in Duluth, Minn., in which Boman[3] reports 3 cases in over 230,000 admissions. Emmett[4] states that not over 300 cases have been reported up to 1946.

The usual initial symptoms are vague, such as progressive weakness, fatigue, loss of weight, and anemia. However, these are later augmented by typical intermittent attacks of small intestinal obstruction with intercurrent periods of relief, during which time the patient feels comparatively well. Pain is variable but is usually present only during the periods of obstruction and is cramplike in character. Usually the obstructive symptoms are present for several months before the nature of the lesion is discovered. Fecal belching and vomiting may be observed. A palpable mass is usually not found. Melena is rarely noted, but occult blood may be present in the stools.

This lesion has been found in the age groups in proportions resembling those in which carcinomas elsewhere in the gastrointestinal tract occur. The average age, according to Ewing,[5] is 46.5 years, and the ratio of males to females is 2 to 1.

X-ray findings are negative in 75 per cent of cases.[6] Despite the presence of an annular lesion with a 1 cm. lumen and a greatly dilated stomach and duodenum, our x-rays gave no hint of its presence even when reviewed postoperatively. Gabor and Hiller[7] have made the statement that the presence of gastric retention for more than eight hours is highly suggestive of small bowel malignancy. Pooling may sometimes be noted in proximal loops of small intestine. The importance of pattern x-ray studies of the small intestine in cases of this nature is stressed by Weinberger and Paltauf,[8] who state that "any bizarre intestinal complaints for which the usual methods of investigation offer no explanation must be further studied by pattern x-rays of the small

intestine." They further advocate that "in view of the frequently inconclusive x-ray findings of small bowel pathology, it is perhaps advisable to resort more frequently to exploratory laparotomy." This may well be an argument for earlier exploration in patients who relate histories of weakness, loss of weight, anemia, and the highly characteristic attacks of intermittent obstruction. The belching of gas with a strong fecal odor played a large part in our decision to explore our patient.

The most characteristic lesion is an annular constricting carcinoma which resembles that so frequently found in the descending colon. It is almost always adenomatous but in rare cases may be medullary, scirrhous, or, still more rarely, colloid. The majority of lesions are situated in the upper part of the jejunum near the ligament of Treitz.[1] They metastasize early to regional nodes, liver, pancreas, retroperitoneal lymphatics, lungs, and bones in the order named.[9] Over one-third of patients have hopeless metastases at the time of operation.[10]

The surgical mortality of carcinoma of the jejunum has been reported at from 20 per cent, in the series of patients operated on at the Mayo Clinic, to 47.4 per cent, in a series of 22 cases collected by Medinger[11] from Boston sources. The prognosis in surviving cases is also very gloomy, and Rankin and Mayo[10] reported no patients alive after three years, the average postoperative length of life being 17.6 months. From a surgical point of view, this is probably partially due to the fact that regional nodes are involved early in the course of the disease and they are frequently located in inaccessible areas. The lymph from the small intestine is collected in a subserous plexus and drains to the nodes, most of which are situated close to the root of the mesentery. Only comparatively few and small nodes are found in the resectable portions of the mesentery. The main nodes are frequently too close to the large main branches of the mesenteric vessels to make resection of this portion of the mesentery possible. Some significance may also be attached to the fact that carcinomas of those portions of the gastrointestinal tract which are concerned with absorption of intestinal contents are more highly malignant than those found in the distal portions of the bowel.

Report of a Case

Mrs. A. C. entered St. Joseph's Hospital of Milwaukee on Jan. 1, 1950. She stated that her present illness had begun about five months previous to entrance, at which time she was a patient at Muirdale Sanitarium for chronic pulmonary tuberculosis. Weakness and anemia, which were thought to be due to tuberculosis, became progessively worse, and she then began to notice episodes of nausea and epigastric cramping accompanied by loose stools. These episodes at the outset lasted only a day or two and then subsided spontaneously and completely for two or three weeks. However, they began to appear more frequently and to produce actual vomiting. During the past few months these attacks of epigastric pain, nausea, and vomiting had increased in severity and frequency and for the past few weeks had been almost constant. The patient stated that in the symptom-free intervals between these attacks her appetite had been good and she had felt relatively well.

She had previously had a partial hysterectomy and oophorectomy. Following this operation a large ventral hernia had developed, requiring the use of a supportive garment. About two and one-half years previously a diagnosis of pulmonary tuberculosis had been made, and she had been admitted to Muirdale Sanitarium, where a right-sided thoracoplasty was performed and streptomycin administered for a period of about six months. She had experienced the menopause about eight years before.

Physical Examination.—The patient was an extremely pale and dehydrated 54 year old housewife who appeared exhausted and acutely ill. She seemed morose and disinterested in people or surroundings. She had an irregular suprapubic incisional scar with a large fascial defect, approximately 15 cm. long and 10 cm. wide. The liver was enlarged. No palpable masses were found. Peristaltic gurgles were normal. During the examination the patient belched and a decided fecal odor was noted. The red blood cell count was 4,730,000, hemoglobin content 12.5 Gm., hematocrit level 50 per cent, and white blood cell count 15,200 with a differential count within normal limits. The blood sugar level was 92.2 mg., nonprotein nitrogen level 50 mg., chlorides 445 mg., carbon dioxide-combining power 58.2 per cent, cephalin flocculation 3 plus, total proteins 7.76 Gm., albumin 4.98 Gm., globulin 2.78 Gm., sedimentation rate 18 mm. in one hour, urine specific gravity 1.030, slight trace of albumin, 2 per cent sugar, acetone negative, and white cells 3 plus.

X-ray of the chest revealed collapse of right side of chest in its upper three fourths, emphysema of left lung, no parenchymal changes, and no fluid. X-ray of the gastrointestinal tract revealed nothing abnormal except slight gastric retention and moderate ptosis of the stomach.

Operation.—Abdominal exploration was performed on Jan. 11, 1950 and a hard, movable mass about the size of a child's fist was palpated under a greatly dilated stomach. The duodenum was enormously dilated and many calculi were palpated in the gallbladder. When the transverse colon was lifted the mass was found in the proximal portion of the jejunum about 10 cm. distal to the ligament of Treitz. Grossly it presented the appearance of an annular constricting carcinoma similar to the lesion so often found in the transverse and descending colon. No metastatic lesions were found and no enlarged regional lymphatics were noted.

The jejunum was transected about 8 cm. distal to the mass, and the end of the distal segment closed. The mesentery to the affected portion of jejunum was then transected as close to the superior mesenteric vessels as possible. After the portion containing the mass was freed, the jejunum was transected proximal to the mass just below the liga-

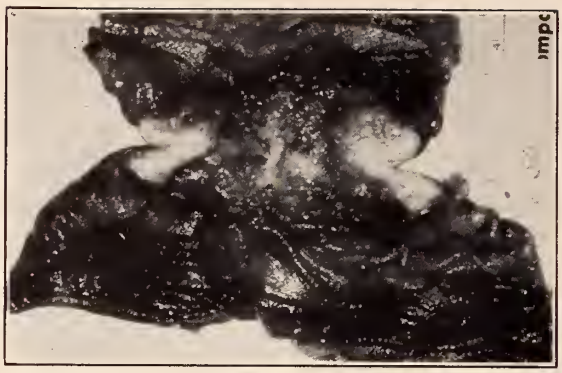

Figure 1.

ment of Treitz and the portion of jejunum containing the tumor was removed. An end to side anastomosis was made between the jejunal segments because of the great difference in size of the proximal and distal segments. No attempt was made to repair the ventral hernia, because a skin or fascial graft was required and the patient's condition did not warrant further surgical treatment.

She made an uneventful recovery and was dismissed from the hospital on the fourteenth postoperative day.

Pathologic Report.—The pathologic report was adenocarcinoma of the jejunum grade II. No tumor cells were found in regional nodes, but the tumor had infiltrated the serosal coat of intestine and had invaded the adjacent mesentery (fig. 1).

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UNIVERSITY OF MICHIGAN ANNOUNCES SCHEDULE OF POSTGRADUATE COURSES

The University of Michigan has announced that the following brief review courses will be offered for practicing physicians during the first half of 1951:

Anatomy ____(Thursdays) February 15–May 31
Cancer ____January 16–19
Internal Medicine
- Diseases of the Heart ____March 19–23
- Endocrinology and Metabolism ____March 26–30
- Rheumatic Disease ____April 2–6
- Allergy ____April 9–13
- Diseases of the Blood ____April 16–20
- Diseases of the Gastrointestinal Tract ____April 23–27

Recent Advances in Therapeutics ____May 3–5
Electrocardiographic Diagnosis ____August 27–September 1
Neurology, Clinical ____May 14–17
Obstetrics and Gynecology ____February 19–March 3
Ophthalmology Conference ____April 23–25
Pediatrics ____February 28–March 3
Roentgenology, Diagnostic ____April 16–20

Further information about the courses may be obtained by writing to Dr. Howard H. Cummings, Chairman, Department of Postgraduate Medicine, 2040 University Hospital, Ann Arbor, Michigan.

Immunization Survey in Rural Dane County

By A. R. ZINTEK, M. D., and PIERCE D. NELSON, M. D.*
Madison

A. R. ZINTEK

Doctor Zintek, a 1934 graduate of the Marquette University School of Medicine, interned at Milwaukee County Hospital and did three years of graduate work in epidemiology at the University of Michigan to earn the degree of D.P.H. in 1947. From 1945 to 1947 he was a resident lecturer in epidemiology and a research assistant in poliomyelitis at the University of Michigan. He joined the Wisconsin State Board of Health in July 1947 as director of the Bureau of Preventable Diseases.

P. D. NELSON

Doctor Nelson graduated from Marquette University of Medicine in 1946. He received his M.P.H. degree from the University of Michigan in 1949, and since then has been a district health officer with the State Board of Health. He is stationed in Madison.

IN ORDER to determine the percentage of infant and preschool children being offered protection and the effectiveness of the public health immunization centers in rural Dane County, a house to house survey was conducted by the Dane County health councils, the Dane County nurses, and members from the State Board of Health.

It is important to know to what extent the infant and preschool children are being offered protection against diphtheria, pertussis, tetanus, and small pox, in order that a vaccination program can be planned to prevent outbreaks of these diseases. Of course, nothing short of complete immunization will prevent a sporadic case from occurring; however, high levels of protection in the population will prevent epidemics and moderately severe outbreaks of these diseases. It is generally known that the mortality from diphtheria and pertussis is greater in the infant group, and it is now common practice to offer immunization for diphtheria, pertussis, tetanus, and small pox during the first year of life. Kendrick and Perkins have studied the effectiveness of pertussis vaccine in preventing cases of whooping cough in Michigan and New York. Godfrey has suggested levels which will prevent severe outbreaks of diphtheria. Compulsory vaccination laws in some states have eliminated small pox from these states, but in some of our western states, where vaccination for small pox is not compulsory, many cases of small pox are still reported annually.

Procedure

Under the guidance of the Dane County nurses, a survey form was prepared, indicating the name, address, date of birth, and date of immunization for whooping cough, diphtheria, tetanus, and small pox. The place where the immunization was done and the family physician was listed. The members of the health councils made the survey during the last two weeks of April 1949, and forms were returned to the nurses' offices by May 10, 1949.

Miss Holland prepared an estimated census of the population living in rural Dane County from birth and death certificates for each of the age groups from 1 year to 5 years inclusive, in order that percentage levels of those being offered protection from diphtheria, pertussis, tetanus, and small pox could be computed. Graphs, charts, and slides were prepared from these data in order to make the material more presentable and understandable.

Results

There were 6,951 infant and preschool children surveyed in rural Dane County, which represented 79.4 per cent of the estimated total census of these age groups in rural Dane County. There were 504 infants below 6 months of age, and they were not considered eligible for protection. Age groups were corrected for the period during which the census was taken and adjusted for the children born in 1949.

Whooping Cough.—For the years 1944 to 1949 doctors have increased the number of immunization procedures being offered to infants less than 1 year

TABLE 1.—*Infant and Pre-School Children Surveyed in Relation to Total Infant and Pre-School Census, Rural Dane County, 1949*

Age	*Census*	*Surveyed*	*% Surveyed*
Under 1 Year	1,619	1,205	74.4
1–2 Years	1,553	1,204	77.5
2–3 Years	1,376	1,255	91.2
3–4 Years	1,260	1,014	80.5
4–5 Years	1,259	965	76.6
5 and Over	1,684	1,308	77.7
Total	8,751	6,951	79.4%

* Authors extend thanks to Mrs. Lucile Graves, the Dane County nurses, Vivian Holland, William Dewey, Mat Schleck, and the State Board of Health, who contributed to this article.

of age and in 1949 39.0 per cent of the infants less than 1 year of age were offered protection from whooping cough in the private physicians' offices.

Of the entire group surveyed, 69.3 per cent of all infant and preschool children have been offered protection from whooping cough. Of this entire group, 48.0 per cent were offered protection in the office of their family physician. Of the entire group surveyed, 30.7 per cent were not offered protection from pertussis.

Diphtheria.—For the years 1944 to 1949 doctors have increased the number of immunization procedures being offered to infants less than 1 year of age, and in 1949 41.7 per cent of the infants less than 1 year of age were offered protection from diphtheria in the private physicians' offices.

Of the entire group surveyed, 69.3 per cent of all infant and preschool children have been offered protection from diphtheria. Of this entire group, 47.7 per cent were offered that protection in the office of their family physician. Of the entire group surveyed, 30.7 per cent were not offered protection from diphtheria.

Tetanus.—For the years 1944 to 1949 doctors have increased the number of immunization procedures being offered to infants less than 1 year of age, and in 1949 37.3 per cent of all the infants less than 1 year of age were offered protection from tetanus in the private physicians' offices.

Of the entire group surveyed, 49.6 per cent of all infant and preschool children have been offered protection from tetanus. Of that number, 39.9 per cent were offered that protection in the office of their family physician. Of the entire group surveyed, 50.4 per cent were not offered protection from tetanus.

Small Pox.—For the years 1944 to 1949 doctors have increased the number of immunization procedures being offered to infants less than 1 year of age, and in 1949 21.9 per cent of the infants less than 1 year of age were offered protection from small pox in private physicians' offices.

Of the entire group surveyed, 54.3 per cent of all infant and preschool children have been offered protection from small pox. Of that number 32.8 per cent were offered that protection in the office of their family physician. Of the entire group surveyed, 45.7 per cent were not offered protection from small pox.

Discussion

It is beyond the scope of this survey to determine the exact level of immunization in this community. To determine the exact level of immunization it would be necessary to evaluate the type of antigens used in vaccine, determine the level of antibodies developed in the children by tests such as the Schick test, and to compare morbidity and mortality data with these levels.

It is interesting that from 1944 to 1949 there has been an increasing tendency to utilize the physicians' services in their offices for immunization procedures.

TABLE 2.—*Percentages of Infants less than 1 year of Age Offered Protection in Physicians' Offices, 1944 to 1949 Inclusive*

Year	Diphtheria, %	Whooping Cough, %	Small Pox, %	Tetanus, %
1944	20.0	20.8	11.4	12.3
1945	22.3	22.9	13.6	18.6
1946	27.1	27.7	16.9	23.7
1947	35.4	35.7	19.6	29.9
1948	35.6	36.1	19.6	32.4
1949	41.4	38.5	21.6	36.7

Although attendance at public clinics did not materially increase until 1949, the number of children being offered protection in physicians' offices has steadily increased during this entire period. The immunization procedure is best carried out in the physician's office, and additional service can be rendered to the infant and the mother; diets, feeding problems, routine physical examinations, and postpartum care are all important. Such points of care are obvious to the physician but should be pointed out from time to time to patients and new mothers.

The continued efforts of physicians to immunize against these diseases is reflected by the steady year by year increase of protection being offered infants below 1 year of age. The level of protection being offered against small pox is well below the present percentage level for the other three diseases. It appears necessary to point out the low level of protection being offered in rural Dane County for small pox.

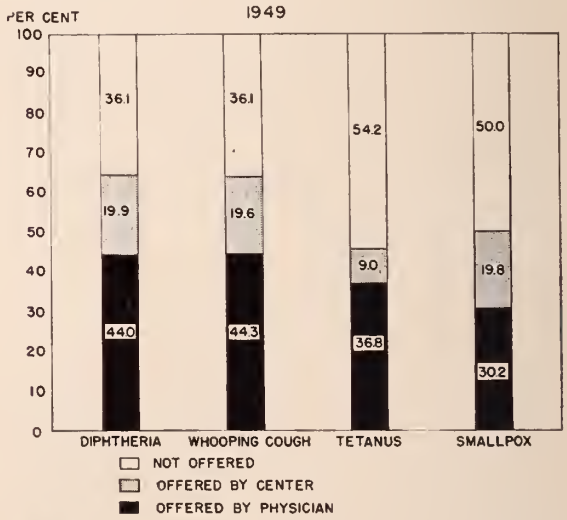

Fig. 1.—Infant and pre-school children surveyed in relation to total infant and pre-school census.

Summary

The status of the levels of protection being offered infant and preschool children in rural Dane County for diphtheria, pertussis, tetanus, and small pox has been presented from the material gathered by the Dane County public health councils.

The increasing tendency to utilize facilities and services in private physicians' offices during the past

five years has been pointed out. The increased attendance at the public clinics apparently is accompanied by an increased number of children coming to the office of their family physician for the purpose of being offered protection from these four diseases.

Although the number of infants and children offered protection is increasing, the survey indicates that 45.7 per cent of the children surveyed lack protection for small pox, 30.7 per cent lack protection for whooping cough, 50.4 per cent lack protection for tetanus, and 30.7 per cent lack protection for diphtheria.

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AMERICAN COLLEGE OF SURGEONS SCHEDULES MEETINGS

A three day sectional meeting of the American College of Surgeons will be held in St. Louis on January 22–24, with headquarters at the Statler Hotel.

The program for the meeting will include new surgical motion pictures, a special program on trauma, a cancer symposium, and panels or papers on vascular surgery, chest injuries, fractures about the ankle joint, hematuria following and emergencies arising during operation, etc. The first two days of the program will be presented at the headquarters hotel, and on January 24 the hospitals in St. Louis will offer a full day of surgical clinics for those in attendance at the meeting.

A $5.00 registration fee will be required except from Fellows and members of the Junior and Senior Candidate Groups of the College and interns and residents. Dr. James Barrett Brown of St. Louis is in charge of the arrangements for the meeting.

Inquiries about the meeting may be sent to the American College of Surgeons at 40 East Erie Street, Chicago 11, Illinois. Requests for hotel accommodations should be sent directly to the Statler Hotel in St. Louis.

BOARD OF EXAMINERS IN BASIC SCIENCES SCHEDULES EXAMINATIONS

The next two examinations of the Wisconsin State Board of Examiners in the Basic Sciences will be held as follows:

December 2, 1950: 8 a. m. to 5 p. m. at the Plankinton House, Milwaukee. The last filing date is November 25, 1950.

April 7, 1951: 8 a. m. to 5 p. m. at the Loraine Hotel, Madison. The last filing date is March 31, 1951.

The Use of Physostigmine and Foreign Protein Therapy in Arthritis and Related Conditions

By A. H. STAHMER, M. D.
Wausau

A. H. STAHMER

The president of the Marathon County Medical Society, Doctor Stahmer received his medical degree from Marquette University School of Medicine. He interned and served a residency at Milwaukee County Hospital before entering private practice in Wausau, where he is on the staffs of Wausau Memorial Hospital and St. Mary's Hospital and the senior member of the Stahmer Clinic.

DURING the past five years several clinical investigators have reported studies on relaxation of skeletal muscle spasm and prevention and correction of deformities in rheumatoid conditions. Hench, Kendall, and Slocumb[1] have recently reported their successful use of compound E (17-hydroxy-11-dehydrocorticosterone) and ACTH in rheumatoid arthritis. This was followed by a report by Hench, Slocumb, Barnes, Smith, Polley, and Kendall[2] on their experience in using the same substances in rheumatic fever. Norcross, Robins, and Lockie[3] used d-tubocurarine for relaxing muscle spasm in rheumatoid arthritis. Previously, observations on the use of neostigmine for relief of muscle spasm and prevention of deformities in rheumatoid arthritis were reported by other investigators.[4,5,6] In 1946 Cohen and his associates[7] reported their observations in treating these same conditions with physostigmine salicylate and atropine sulfate. They found that a combination of physostigmine salicylate and atropine sulfate is at least equally as effective an antispasmodic for skeletal muscle spasm as is neostigmine and that physostigmine has the advantage of being somewhat less toxic. They reported that the combination of these two drugs produced relief of skeletal muscle spasm in patients suffering from rheumatoid arthritis and it prevented the formation of deformities or decreased considerably the extent of deformities already formed.

During the past year my associates and I have been using a combination of physostigmine salicylate and atropine sulfate and a solution containing nonspecific protein supplemented with methionine, thiamine hydrochloride, and ascorbic acid. These medications are administered intramuscularly. We have found them to be an effective, convenient, and inexpensive means of producing muscular relaxation and correcting deformities in patients with chronic rheumatoid disease.

Pharmacologic Action

Physostigmine is a cholinergic drug. It reduces physiologic reactions controlled by the parasympathetic system. Acetylcholine is the chemical mediator formed at the synapse which transmits the impulse from the dendrites of one nerve to the dendrites of the second. It is water soluble. To prevent an accumulation of acetylcholine in the body, there is a cholinestearase which hydrolyzes and neutralizes its physiologic action. Physostigmine inhibits the action of cholinesterase, allowing acetylcholine to increase and exert its characteristic physiologic effects. The cholinergic action of physostigmine is readily observed in its action on smooth muscle. The mechanism of the pharmacologic action of physostigmine on skeletal muscle is not so clear. It does, however, break the reflex arc set off by pain impulses from end organs of the pain nerves at the affected joint, causing reflex motor impulses to the muscles adjacent to the affected joint. Thus, in some unexplained way physostigmine blocks the return of the motor component of the reflex impulse.

Physostigmine decomposes and loses its activity rapidly in aqueous solutions unless the solutions are stabilized.* If a stabilized solution is not available, then a fresh solution must be made up for each injection.

Atropine sulfate is an antagonist of physostigmine salicylate in its action on smooth muscle, in salivary stimulation, and in inducing menses.

Foreign protein therapy stimulates leukocytosis, increases phagocytosis, and facilitates mobilization of immune bodies, all of which are beneficial in the treatment of an infection. Beef peptone has the advantage over bacterial vaccines and certain other foreign protein preparations in that it does not induce a fever, marked foreign protein reaction, and malaise. It is not fraught with the hazard of uncontrollable fever, such as follows vaccines and other forms of foreign protein therapy, or the formation of antigens in the body. Reactions following its use are exceedingly rare. dl-Methionine is a sulfur-containing essential amino acid which is important

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* A stabilized solution of physostigmine salicylate with atropine sulfate is supplied by Kremers–Urban Company, Milwaukee, under the name of Phyatromine(R). Each cubic centimeter contains 0.6 mg. each of physostigmine salicylate and atropine sulfate. Phyatromine was used throughout the investigation.

in protein metabolism and in detoxification processes. It supplies sulfur to the body for use in the synthesis of other important compounds. Thiamine hydrochloride corrects any existing thiamine deficiency which might be manifested as anorexia, constipation, or neuritis. It improves gastrointestinal tone and appetite. Freyberg[9] states that the water-soluble vitamins most frequently deficient in arthritic patients are thiamine hydrochloride and ascorbic acid. These deficiencies are not the cause of the arthritis, but probably develop as a result of the alteration in dietary habits of the arthritic patient due to pain, discomfort, and discouragement over the crippling condition of arthritis. Recently it has been shown that salicylates lower the threshold of the kidney for ascorbic acid. Consequent to this the plasma ascorbic acid level drops. Nungester[10] has shown that the activity of the leukocytes varies with the plasma ascorbic acid level. As the level drops leukocytic activity is decreased. Since salicylates are frequently given for their analgesic and probably therapeutic effects in rheumatoid conditions, consideration should be given to providing the patient with an ample supply of ascorbic acid.

For convenience of injection, foreign protein, dl-methionine, thiamine hydrochloride and ascorbic acid were supplied in a single injection. Each cubic centimeter contained beef peptone, 50 mg.; dl-methionine, 5 mg.; thiamine hydrochloride, 25 mg.; and ascorbic acid, 25 mg. *

Procedure

The patients included in this study, with few exceptions, had been afflicted with various forms of arthritis and related rheumatoid conditions for several years. The majority of them had been under our care for from two to eight years. The series included both males and females, and the ages ranged from 33 to 79 years, most of the patients, however, being in the age range of 50 to 60. In general, the major complaint of these patients was discomfort and pain incident to muscle spasm and deformity due to their arthritic condition. Most of these patients were ambulatory, although movement was accompanied by marked discomfort and pain. This group of patients included 43 who were diagnosed as having rheumatoid arthritis, 25 as having hypertrophic arthritis, 3 with intercostal neuralgia, 4 with sciatica, and 4 with muscle spasm incident to scoliosis.

When these patients first presented themselves for treatment they were given a thorough physical examination, with complete blood chemistry, differential blood cell count, sedimentation rate, urinalysis, Wassermann test, and x-ray of the affected parts. Every effort was made to discover the infection which might be the precipitating cause of the rheumatoid condition. The teeth were checked by a dentist and the tonsils were examined. If either gave evidence of infection, their removal was recommended. The nasal sinuses were examined. A smear was made to preclude prostatitis. In females, a complete gynecologic study was made. The cervix was examined for endocervicitis. X-ray photographs were taken of the intestinal tract, including the large bowel, and the biliary tract. Both were checked for possible dysfunction which might be a causative factor. The majority of the patients in this series had been treated for their arthritic condition by us during the preceding several years by the accepted forms of therapy and the particular form receiving the greatest interest at that time.

Previous treatment had been directed to the improvement of the nutritional state and relief from the anemia generally present by administration of liver extract, iron, the factors of the vitamin B complex, and a high caloric diet. At various times attempts were made to remove the infection with administration of penicillin, sulfonamides, or streptococcus antigens. Other types of therapy used were bee venom, gold therapy, nicotinic acid, and diathermy. All of these were ineffectual in permanently relieving the pain and discomfort and in correcting the deformities attending the rheumatoid arthritis.

Treatment in this study consisted in giving the patients injections of physostigmine salicylate and atropine sulfate (Phyatromine(R)) and beef peptone, methionine, thiamine hydrochloride, and ascorbic acid (Pantodren(R)). The initial injection consisted of 0.5 cc. of Phyatromine(R) and 1 cc. of Pantodren,(R) withdrawn and mixed in a single syringe. Subsequent injections consisted of 1 cc. of each of the two medications. The injections were given intramuscularly, either in the arm or in the buttock. The initial injection of Phyatromine(R) was small, in order to determine the patient's responsiveness to physostigmine and atropine. Ordinarily the first three or four injections were repeated at three or four day intervals. Subsequent injections were spaced according to the need of the patient.

Patients were instructed to eat a high caloric diet supplemented with vitamins. At first salicylates were used adjunctively to give the patient relief from pain, but this was found to be unnecessary, since the injections were generally followed by relief of pain.

Results

In each instance the patients with rheumatoid arthritis reported on their next visit that they had experienced an increased freedom of motion of the affected joints within 30 minutes after receiving their first injection. Subsequent injections produced further relief from muscle and joint stiffness. Pain and discomfort incident to the attendant muscle spasm diminished with relaxation of the associated muscles. Improvement of articular and muscular function was followed by reduction of deformities. Generally there was a prompt relief from general muscular tension.

* This is available under the name of Pantodren from Kremers–Urban Company, Milwaukee.

Every patient obtained some degree of relief from pain and increased mobility of joints. In some instances the improvement was dramatic. After a series of injections, patients who were unable to feed themselves, to comb their hair, to dress without some help, or to take care of their own hygiene were able to carry out these complex and coordinated movements with more or less complete facility. Some patients who previously were homebound returned to gainful employment. There was an improvement in appetite, a gain in weight, and an improvement in mental outlook. This was due, no doubt, in part to relief from the psychic effect of having a crippling disease.

In general, patients with chronic rheumatoid arthritis experienced a greater degree of relief from discomfort and greater freedom of motion than did those patients with the acute form following the first few injections. Discomfort in the acute form is due to the distention and inflammation of the soft tissues about the affected joints. The decrease of tension on these soft tissues, resulting from skeletal mucle relaxation, gave partial and progressive relief from pain.

Only patients with hypertrophic arthritis who were experiencing considerable discomfort and limitation of motion were included in the series. These patients reported an increased freedom of motion; they were relieved of their muscle tension; and they felt better.

Patients were instructed at the time of their injections to return for another injection when they felt the need for relief. Fifty per cent returned on the third or fourth day, 40 per cent returned on the sixth or seventh day, and 10 per cent from the seventh to the fourteenth day. In a total of 328 injections given to 58 patients, the number of injections necessary to give improvement in muscle and joint function and marked or maximum relief from pain and discomfort ranged from 2 to 17. The majority of patients received three to eight injections. There was an average of 6.5 injections per patient. Three patients of the series received 15, 16, and 17 injections respectively. After the first two or three injections, many patients spaced their requests for injection within two to four weeks, after which they generally returned monthly. No attempt was made to have the patients space their injections at regular intervals. In cases in which a course of daily injections is possible, it would seem desirable to give daily injections for a week or ten days, to obtain maximum relaxation as soon as possible.

There were no side effects observed, except for drying of the mouth in some patients and an occasional slight blurring of vision.

X-ray pictures of affected areas after a period of treatment showed that the arthritic process still remained. The use of Phyatromine(R) and Pantodren(R) is directed to giving the patient relief from discomfort and the crippling effects of arthritis, but thus far there is no evidence that it affects the arthritic processes already developed.

Figure 1

Phyatromine(R) and Pantodren(R) were given in 3 patients with intercostal neuralgia, in 4 patients with sciatica in which there was some spasm of leg muscles, and 4 patients with scoliosis with considerable pain due to back muscle spasm. These patients were relieved of their muscle tension.

Three cases in the series are of unusual interest and warrant separate discussion.

Case 1.—Mrs. F. H., a 65 years old patient with osteoarthritis of long standing, came to our clinic July 16, 1948. She walked with great difficulty and was in severe pain. She was given a thorough physical examination, including an x-ray photograph of the left hip, and the usual clinical tests were made. Her sedimentation rate was 7 mm.; hemoglobin was 75 per cent; and red cell count, 3,680,000; the Wassermann test was negative. The x-ray photograph showed (fig. 1) almost complete ankylosis of the left hip. She was given thiamine hydrochloride and liver injections to improve the blood picture and her general nutritional state. On Sept. 3, 1948, a series of injections of Phyatromine(R) and Pantodren(R) was started. Subsequent injections were given on October 29, November 18, December 2, January 5, 12 and 26, February 10 and 24, and March 10 and 24. She is now practically free from pain; she has free motion in the joints and is now able to climb stairs. She feels good generally and her outlook on life has changed. She is grateful for the benefit derived from this therapy. By July 25 she had not returned for another injection.

Case 2.—Mrs. H. R., chronic rheumatoid arthritic patient, had been under my care since 1940, at which time she was 60 years of age. She had been given injections of estrogens, gold, liver and thiamine hydrochloride, streptococcus antigen, and sulfur at various times during the intervening years. On Nov. 1, 1948 she was in severe pain and unable to move. She was given a thorough physical exam-

Figure 2

ination, and the usual clinical laboratory tests were made. An x-ray photograph showed arthritis of the spine. She was given liver injections with thiamine hydrochloride for anemia, and three injections of penicillin during the succeeding three months. On Jan. 20, 1949, she was given an injection of Phyatromine and Pantodren. She returned for subsequent injection on March 3, 4, 9, 14, 18, 22, 31, April 11, June 6, 13 and 21. On July 18, she returned for a check-up and reported that she was experiencing no discomfort from her arthritis and that another injection was unnecessary.

CASE 3.—Mrs. B. B., aged 64, came to our clinic on Jan. 10, 1949. Examination showed that she had a third degree prolapse of the uterus. Routine examination revealed coexisting diabetes with a blood sugar level of 315 plus. She had arthritis of the hip, which made walking difficult. She had only a nominal degree of flexion at the hip joint. The prolapse was repaired surgically and the diabetes was controlled with insulin. On May 2, she complained of the persistent pain in her right hip. An x-ray photograph showed apparent ankylosis (fig. 2). An injection of Phyatromine(R) and Pantodren(R) was given. She returned three days later for a second injection, reporting that she obtained a great deal of relief from the injection. Subsequent injections were given on May 9 and 23 and June 6, 14 and 21. She returned on July 5 for a check-up. She said that she felt comfortable and did not need another injection.

Discussion

The clinical effects following the use of Phyatromine(R) and Pantodren(R) in chronic rheumatoid arthritis include improvement in muscle and joint function and relaxation of skeletal muscle spasm, with reduction of deformities, the extent of reduction depending upon the amount of fibrosis or ankylosis that had occurred about the joint. Patients with chronic rheumatoid arthritis obtained more relief promptly than did patients with the acute form.

Generally, improvement of motion of the affected joints is evident within 30 minutes. Further relief of stiffness is accomplished by repeated injections twice weekly. The rate and extent of improvement vary from patient to patient. With improvement in muscular and articular function, there is a decrease of pain and tenderness of soft structures about the affected joints. Patients regain, more or less completely, their ability to execute complicated movements requiring muscle coordination.

Patients experience an improvement in appetite; they gain weight; and their outlook on life is markedly improved.

Patients with hypertrophic arthritis experienced relief from tension and discomfort when these had been present before treatment.

Treatment with Phyatromine(R) and Pantodren(R) is palliative. Duration of relief from stiffness varies. After maximum relief is obtained, ordinarily monthly injections are sufficient. In some cases the interval between injections has been as long as four months. When treatment is started, injections should be given twice weekly or more often if possible.

If the patient does not show improvement in muscle and joint function within two weeks, further efforts will be fruitless. In our experience, however, all rheumatoid patients experienced some benefit from the medication.

Our observations confirm the findings of Cohen and his associates[7, 8] in the usefulness of a combination of physostigmine salicylate and atropine sulfate to reduce skeletal muscle spasm in rheumatoid arthritis and to prevent or reduce deformities incident to muscle spasm.

By means of the medications which are the subject of this investigation, it is possible to obtain muscle relaxation as effectively, more quickly, and more conveniently than can be accomplished by physiotherapy methods and with less cost to the patients. Relaxation with Phyatromine(R) permits muscle and joint motion, which in itself produces more relief from the associated skeletal muscle spasm.

It should be pointed out that in this investigation patients were not requested to return for injections at stated intervals, but were allowed to decide for themselves when they felt the need for more relief from their stiffness. We feel that the voluntary return of patients is evidence that the injections gave them relief, and the time intervals between injections are a measure of their lasting effect.

Summary and Conclusions

1. Phyatromine(R) and Pantodren(R) were used successfully in the treatment of a series of 80 patients with rheumatoid and hypertrophic arthritis and related rheumatoid conditions.

2. Phyatromine(R) is a valuable adjunct in the palliative treatment of these conditions. It has an antispasmodic action on skeletal muscle. Relaxation of muscle tension and improved joint and muscle motion are generally evident within 30 minutes.

3. Phyatromine(R), by relaxing skeletal muscle spasm, makes possible better joint function and decreases the extent of deformity about a joint. The patient regains his ability more or less completely to execute complicated muscle and joint movements.

4. Phyatromine(R) reduces pain and tenderness about joints in rheumatoid arthritis as a result of its antispasmodic action.

5. Because Phyatromine(R) relieves pain and tenderness through relaxation of muscle spasm and allows better muscle and joint function, thus permitting some patients to return to gainful employment, it has a good psychologic effect upon the patient.

6. Pantodren(R) is a valuable medication for the treatment of the arthritic process through its nonspecific protein and through the improvement of the nutritional state and general metabolism of the patient.

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UNIVERSITY MEDICAL SCHOOL TO PRESENT CARDIOLOGY COURSE

A postgraduate course in cardiology will be given at the University of Wisconsin Medical School, November 28–30. Information regarding the presentation may be obtained from Dr. Robert C. Parkin, 418 North Randall Avenue, Madison 6.

The opening day will consist of a discussion on the classification of heart disease by Dr. H. H. Shapiro; a cardiac consultation by the cardiology staff; a talk on the psychosomatic aspects of cardiovascular disease by Dr. M. J. Musser; a discussion of coronary disease by Dr. W. S. Middleton; and a clinical–pathologic conference conducted by Dr. D. M. Angevine. Following ward rounds and a cardiac consultation with the cardiology staff on Wednesday, a movie on the "Management of the Failing Heart" will be shown. Dr. J. W. Gale will discuss congenital heart disease; Dr. C. M. Kurtz will speak on rheumatic fever; and Dr. O. O. Meyer will present a discussion of subacute bacterial endocarditis. The concluding morning will be spent in ward rounds and a cardiac consultation; in the afternoon Dr. J. L. Sims will speak on hypertension and hypertensive heart disease; Dr. T. C. Erickson will discuss the surgical treatment of hypertension; and Dr. O. S. Orth will talk about therapeutic agents. The course will be concluded with an x-ray conference conducted by Dr. L. W. Paul.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Additional Thoughts About Herpes Zoster

In the February issue of this *Journal*, Doctor Beckman discussed newer drugs proposed for the treatment of herpes zoster. It seems to the undersigned that a few additional points may well be added thereto, in the nature of "Comments."

This very painful and occasionally extremely serious condition apparently chiefly involving the ganglia of sensory nerves, with peripheral manifestations, has been subject to empirical treatment for a great many years. Recently, many more or less successful, yet generically different, remedies have been described which make it difficult to rationalize the treatments or even the unique nature of this disease, whose basic etiology is now generally considered to be a virus.

An older method of treatment was, and still is to some extent, the use of analgesics such as the opiates to control the very severe pain, and then depend upon the patient to wear down the infection and attain at least a state of apparent cure.

Some of the agents purported to be of effective service in the treatment of herpes zoster are as follows: diphtheria antitoxin, sodium iodide, pituitrin, thiamine, x-ray, pitressin, procaine, liver extract, smallpox vaccination, vitamin B_{12} carbon tetrachloride, Etamon, Chloromycetin, Aureomycin, and ergot preparations.

With such an array of different remedies with their respective advocates, each of whom probably feels convinced that his is the best, one is at a loss as to how to make a choice. Perhaps by the time two or three remedies have been tried in succession, the patient will have worn down the disorder, maybe more or less spontaneously, and the last drug or treatment employed gets the credit for the cure.

Among the remedies listed above, some are of rather unusual interest because of the special implications involved. The use of procaine in this disease recalls to mind the occasional use of this drug in sciatic rheumatism or sciatica. An injection of procaine into or around the sciatic nerve may completely relieve the pain, at least temporarily, and occasionally more or less permanently. Why this is so is completely unknown. Perhaps one could describe the event by saying that the "habit" or "vicious cycle" has been broken by the local anesthetic. Now, what can be said about the topical use of procaine or carbon tetrachloride in the treatment of herpes zoster? It is known that carbon tetrachloride, applied to the very common acutely painful hot grease spatter-spot burns, e.g., on hands and arms of cooks, causes a remarkable relief. The undersigned can state that this holds true also for the pain or itching of mosquito bites. Does the carbon tetrachloride antidote the poison or simply anesthetize the area so reflexes? Perhaps, in a fashion, it acts somewhat as that the forces of repair are not hindered by local do the local anesthetics in the relief of sciatica.

Since leukocytes have been found in or about the dorsal root ganglia in certain cases in which thoracic nerves appear to be involved, irradiation has been suggested on the basis of leukocytic radiosensitivity. Some evidence has been reported of therapeutic value of irradiation but it certainly is difficult to rationalize this procedure. Is the presence of leukocytes responsible directly or indirectly for the pain, which is relieved on the destruction of these same leukocytes?

Drugs acting on smooth muscles or on cell membranes may alter permeability and might then produce peripheral changes responsible for relief of pain. Perhaps it would be of interest to draw an analogy between the nonspecific agents said to be effective in herpes zoster and the first drug known to be effective in typhus fever, namely, para-aminobenzoic acid (PABA). During the second world war this simple compound, a constituent of the B-group of vitamins, was found to be somewhat effective on rickettsial infections in chick embryos. Since no other drug was known to be effective up to that time, it was employed in the treatment of typhus fever, and with very evident benefit to the patient in spite of the fact that the infective organisms were not at all directly affected. Apparently the beneficial effects were due to some protection against the effects of the rickettsial bodies on the endothelium of blood vessels, which presumably leads to petechial hemorrhages. Hence it is reasonable to suppose that the course of herpes zoster may be made tolerable, less dangerous, and even relatively painless through the action of some of the above mentioned agents, even though by indirect mechanisms. The two antibiotics, Chloromycetin and Aureomycin, certainly appear to be specific against rickettsial organisms and perhaps even against the virus of herpes zoster. However, more evidence must be awaited, since an almost equal amount of enthusiasm has been shown towards most of the other "cures." In general, viruses are quite resistant to chemotherapy, and if this virus actually does yield to drugs it would constitute a marked and hopeful advance—another virus disease responding to antibiotics.—A. L. TATUM, M. D.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Know Your Endorser

The man whom you little know from around the corner presents himself with a five dollar check. Will you cash it? Perhaps, but how about his check for a hundred dollars, a thousand dollars? Specifically, how about the check which has to do with the patient's health and perhaps his life? We know, doctor, that you do not accept checks unless you know the other party and that you certainly must follow the oft repeated warning of your bank, "Know your endorser."

In the *Woman's Home Companion*, April 1950, Albert Deutsch calls the laity's attention to "The Menace in the Medical Laboratories." Lest this passes without being understood by every physician, we must call it to your attention. The essence of the problem presented by Mr. Deutsch is this: Do you *know your laboratory and the endorser of your laboratory data?* Do you know the "check writer" whose values concerning health, illness, and death you are asked to cash? Do you know what his facilities are? Have you checked his "Dunn's report"? Where does he stand in the field of laboratory medicine? Above all, is he a doctor of medicine, and can he place any laboratory report next to the patient and with you interpret it so that the patient may be promptly and correctly diagnosed and treated? Blind acceptance of laboratory data from just any so-called medical laboratory is apt to be associated with a diagnostic account which is short, and your patient stands to lose . . . perhaps his life.

Albert Deutsch states that there are two to three million illnesses erroneously diagnosed each year because of laboratory irregularities. No one can deny that errors occur in recognized laboratories with qualified directors constantly on the watch and his qualified technicians also constantly on the watch. However, just imagine how this can be multiplied when there is no qualified doctor to endorse the "check" of diagnostic data.

The laboratory technician working alone or with other technicians, regardless of background and experience, can never *diagnose disease* or *interpret laboratory data.* It means then that the operation of a laboratory by such individuals must center about turning out reports and when there is no qualified endorser it more and more becomes purely a mass production of reports for monetary gain. The uninitiated clinician using such reports unknowingly throttles prompt and accurate diagnosis of his patient's illness. Regrettable, too, is the fact that many clinicians do not want a result or a report of a test; they want a *diagnosis* and expect it from a technician. The technician does not diagnose. She performs an examination and submits a value or a report. The *doctor* applies the information to other data before him and then he makes the diagnosis. The diagnosis of illnesses is a practice of medicine and for the patient's protection must be reserved for the qualified doctor of medicine. One cannot stress too strongly that there are many more digits on two hands than there are laboratory reports which by themselves are specifically diagnostic and need not be interpreted in the light of history, physical findings, etc. What chance, then, does one have of making a reasonable diagnosis of an illness if the laboratory data used come from questionable sources? It is imperative for adequate care of the patient that the doctor know the endorser of his laboratory tests.

It has been pointed out by some that any laboratory service is better than no laboratory service at all. My dear colleague, nothing can be farther from the truth; for what is the patient's gain if the historical and physical facts of the case are relegated to the background by an erroneous laboratory report? Can your endorser of laboratory data recognize an erroneous report? Can he quickly and quietly mesh the gears of laboratory medicine and clinical medicine and thus help in bringing about the prompt recovery of your patient? If so, firmly bind him into your armament of illness diagnosis and patient care. But if such is not the case, then seek him relentlessly and settle not for less . . . for even you may yet be the patient and will *then* most certainly want to *know the endorser of your laboratory reports.*—J. F. Kuzma, M. D.

COLLEGE OF SURGEONS VOTES TO CONTINUE STANDARDIZATION PROGRAM

At a meeting on October 21, the regents of the American College of Surgeons voted unanimously to continue the hospital standardization program of the College. A spokesman for the regents stated that this action does not necessarily preclude consideration of proposals for the participation of other interested agencies in this program, but does make it clear that the American College of Surgeons has an undiminished interest in it and will consider no proposal which will not insure its continuation in the best interests of the public.

THE MEDICAL FORUM

REVEAL PLANS FOR 1951 POSTGRADUATE CLINICS

Essential M.D.'s May Get II-A Deferments

Madison, Nov. 1.—State Selective Service is giving consideration to communities whose health services or standards would be seriously impaired by a physician leaving for military service.

Doctors who qualify for deferment as essential to community health can be placed in Class II-A by their local draft boards.

Deferments for Class II-A are recommended by the State Advisory Committee to Selective Service on Medical, Dental, Veterinarian and Other Specialists, which uses the state medical society offices as headquarters.

Class II-A deferments are currently being granted only if it is determined that:

1. **The service being performed by the doctor in his community is necessary to the maintenance of the national health, safety or interest.**
2. **Such service cannot be performed by others who are in the community.**
3. **The doctor cannot be replaced in the community by another person who can perform such medical services.**
4. **The doctor's induction will cause the availability of essential health services to fall below reasonable minimum standards.**

The local draft board shall give consideration to but is not bound by the recommendation of the advisory committee on deferments for essential needs.

Special Features for GP at Cleveland

Chicago, Oct. 27.—The AMA clinical session in Cleveland, December 5–8 will feature many subjects of special interest to the general practitioner.

The complete program is printed in the October 21, 1950 issue of the AMA Journal.

County Public Relations Program for Doctors at Cleveland Meeting

Chicago, Oct. 27.—Public relations for the county medical society is the theme of the third annual medical public relations conference of the AMA. It will be held December 3–4 in Cleveland, just prior to the AMA clinical session.

All doctors are invited to attend this PR conference.

Discussions of successful public relations programs will include who directs the work, who pays the bills, finding the sore spots, charting the objectives, and building support.

Other sessions will outline purposeful activities in which doctors may participate, such as working with other professions.

Draft Boards Now Classifying Doctors

238 Doctors Registered

Madison, Oct. 31.—The total of 13,968 doctors who registered on October 16 under provisions of the doctor-draft was well above Selective Service estimates.

In Wisconsin a total of 238 physicians in the first two priorities registered. Also registered at the same time were 107 dentists and 66 veterinarians.

Right now, local draft boards are classifying the registrants in hopes of reporting the number and classification (1-A, 4-F, etc.) of all men in the first category by November 15.

Local draft boards will not make a final classification of any physician, dentist or veterinarian until it has reviewed the recommendations of the State Advisory Committee to Selective Service on Medical, Dental, Veterinarian, and other Specialties.

The advisory committee rules only on the doctor's essential status in the community. The local board's decision on classification is final, but appeals may be made to Selective Service.

(See Page 1028 for Details of Programs)

Madison, Nov. 1.—The new series of "one-night stand" postgraduate clinics designed to bring medical education to the doctor's doorstep will get a four-month trial starting next January, **if a minimum of 150 physicians per circuit can be assured.**

Registration blanks will be distributed to all physicians within the next two weeks.

The western circuit, serviced by the faculty of the University of Wisconsin Medical School, will include La Crosse on Tuesday nights and Wednesday mornings; Eau Claire on Wednesday nights and Thursday mornings, and Wausau on Thursday nights and Friday mornings.

The eastern circuit, serviced by the faculty of Marquette University School of Medicine, will include Oshkosh on Tuesday nights and Wednesday mornings; Marinette and Menominee, Mich., on Wednesday nights and Thursday mornings, and Green Bay on Thursday nights and Friday mornings.

Nine Sponsors

Sponsoring this educational innovation are the state medical society's council on scientific work; state board of health, the two medical schools, Wisconsin Academy of General Practice, Wisconsin Anti-Tuberculosis Association, Wisconsin Chapter of the National Foundation for Infantile Paralysis, Wisconsin Division, American Cancer Society, and the Wisconsin Heart Association.

The steering committee planning the schedule includes Dr. Bump, Dr. Donald Ausman, Milwaukee, for the Academy for General Practice; Dr. Lamont Schweiger, Milwaukee, for the heart association; Dr. E. H. Jorris, Madison, for the board of health; Dr. Robert Parkin, Madison, for the University of Wisconsin Medical School, and Dr. E. A. Bachhuber, Milwaukee, for the Marquette School of Medicine.

Postgraduate Clinics

WESTERN CIRCUIT

LA CROSSE—Tuesday P. M. Lectures; Wednesday A.M., hospital conferences

EAU CLAIRE—Wednesday P.M., lectures; Thursday A.M., hospital conferences

WAUSAU—Thursday P.M., lectures; Friday A.M., hospital conferences

Jan. 30–31, Feb. 1
Differential Diagnosis and Management of Cancer of the Breast"—A. R. Curreri, M. D., Madison
"The Arrhythmias"—H. H. Shapiro, M. D., Madison

Feb. 13–14–15
"Meeting Common Obstetric Emergencies"—to be announced
"Convulsive Disorders in Children" —K. B. McDonough, M. D., Madison

Feb. 27–28, Mar. 1
"Psychosomatic Medicine"—M. J. Musser, M. D., Madison
"Uses and Abuses of New Drugs" —to be announced

Mar. 13–14–15
"Differential Diagnosis and Management of Cancer of the Uterus"—R. E. Campbell, M. D., Madison
"Rheumatic Heart Disease"—to be announced

Mar. 27–28–29
"The Management of the Third Stage in Labor"—to be announced
"Modern Therapy of the Otologic Problems in Children and Adults"—to be announced

Apr. 10–11–12
"Differential Diagnosis of Chest Diseases"—J. W. Gale, M. D., Madison
"X-ray Interpretation of Chest Films"—L. W. Paul, M. D., Madison

Apr. 24–25–26
"Differential Diagnosis and Management of Cancer of the Lower Bowel"—A. R. Curreri, M. D., Madison
"Arteriosclerotic Heart Disease and Hypertension"—J. L. Sims, M. D., Madison

May 8–9–10
"A Few Problems in Prenatal Care, Including the Rh Negative Mother"—R. E. Campbell, M. D., Madison
"Effective Procedures in the Care of Prematures (Including Care of the Child of an Rh Negative Mother)"—J. E. Gonce, M. D., Madison

May 22–23–24
"Skin Manifestations of Systemic Diseases"—S. A. M. Johnson, M. D., Madison
"Peripheral Vascular Diseases"—to be announced

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Postgraduate Clinics

EASTERN CIRCUIT

OSHKOSH—Tuesday P.M., lectures; Wednesday A.M., hospital conferences

MARINETTE-MENOMINEE—Wednesday P.M., lectures; Thursday A.M., hospital conferences

GREEN BAY—Thursday P.M., lectures; Friday A.M.; hospital conferences

Jan. 30–31, Feb. 1
"Meeting Common Obstetric Emergencies"—Jack A. Klieger, M. D., Milwaukee
"Convulsive Disorders in Children" Niels L. Low, M. D., Racine

Feb. 13–14–15
"Psychosomatic Medicine"—R. A. Jefferson, M. D., Milwaukee
"Uses and Abuses of New Drugs" —M. C. F. Lindert, M. D., Milwaukee

Feb. 27–28–Mar. 1
"Differential Diagnosis and Management of Cancer of the Uterus"—Roland Cron, M. D., Milwaukee
"Rheumatic Heart Disease"—Lamont R. Schweiger, M. D., Milwaukee

Mar. 13–14–15
"The Management of the Third Stage in Labor"—F. Jackson Stoddard, M. D., Milwaukee
"Modern Therapy of the Otologic Problems in Children and Adults"—Gerhard D. Straus, M. D., Milwaukee

Mar. 27–28–29
"Differential Diagnosis of Chest Diseases"—Einer R. Daniels, M. D., Milwaukee
"X-ray Interpretation of Chest Films"—Jerome L. Marks, M. D., Milwaukee

Apr. 10–11–12
"Differential Diagnosis and Management of Cancer of the Lower Bowel"—Joseph M. King, M. D., Milwaukee
"Arteriosclerotic Heart Disease and Hypertension"—F. D. Murphy, M. D., Milwaukee

Apr. 24–25–26
"A Few Problems in Prenatal Care, Including the Rh Negative Mother"—George S. Kilkenney, M. D., Milwaukee
"Effective Procedures in the Care of Prematures" (Including Care of the Child of an Rh Negative Mother)—Samuel E. Kohn, M. D., Milwaukee

May 8–9–10
"Skin Manifestations of Systemic Diseases"—Leonard S. Markson, M. D., Milwaukee
"Peripheral Vascular Diseases"—James M. Sullivan, M. D., Milwaukee

May 22–23–24
"Differential Diagnosis and Management of Cancer of the Breast"—James G. Garland, M. D., Milwaukee
"The Arrhythmias"—Francis F. Rosenbaum, M. D., Milwaukee

VA HALTS USE OF NAVY HOSPITALS

Washington, D. C., October 2.—The Veterans Administration has instructed its regional offices to stop admisison of veterans to Naval hospitals except in an emergency.

The action was taken at the request of the Department of Defense which is faced with a need for more hospital beds due to the Korean situation.

The Department of Defense also pointed out that a total of 3,880 beds in Naval hospitals has been allocated for Army and Air Force patients.

Urge Cancer Detection by Every Physician

Milwaukee, Oct. 2.—Every doctor's office should be a cancer detection center.

That's the opinion of the state medical society House of Delegates after adopting a report of the committee on cancer headed by Dr. A. R. Curreri, Madison.

Experience with cancer detection centers set up outside the physician's office for mass detection purposes shows that they do not produce satisfactory results.

The House urged every doctor to encourage patients to come in for a cancer check-up in his own office, and to prepare himself to do a proper detection examination.

Doctors were also warned not to make "excessive charges" for such examinations.

BLUE SHIELD OFFERS FIVE CONTRACTS FOR SUBSCRIBERS; PLAN FOUR OTHERS

Madison, Nov. 1.—Benefits are being provided to subscribers of Blue Shield of Wisconsin, formerly Wisconsin Physicians Service, through five separate contracts, and four other contracts are under consideration.

This was reported today by Dr. E. M. Dessloch, Prairie du Chien, chairman of the directing Board of Blue Shield of Wisconsin. The plan is an agency of the state medical society.

He described the five existing contracts as follows:

1. THE STANDARD GROUP CONTRACT—provides benefits for surgery, medical care, anesthesia, x-ray and maternity. Unless 75 per cent or more of a group are enrolled, benefits for tonsillectomies and adenoidectomies are not available until after nine months of consecutive protection and no pre-existing condition is covered until after a nine months' waiting period.
2. BY WAIVER, the standard group contract waiting periods and restrictions are rescinded if a sufficient percentage (75 per cent or more) of the group enroll in the program.
3. GROUP CONVERSION CONTRACT — replaces the standard group contract for those persons leaving the group, but wishing to continue their protection. The cost is higher, but at present the benefits are the same as a standard group policy.
4. NON-GROUP CONTRACT—sold only to individuals on a direct bill basis. It eliminates any benefits for maternity and requires an eleven month waiting period for tonsillectomies, adenoidectomies and pre-existing conditions.
5. SURGICAL - MATERNITY GROUP CONTRACT — same as the standard group contract except that it eliminates benefits for anesthesia, x-ray and medical care.

Dr. Dessloch reported that the following contracts are in preparation:

1. Riders, containing benefits for radiology, anesthesia and medical care, which may be sold in connection with surgical–maternity contracts so that such contracts may contain additional benefits for any one or all three services.
2. A rider extending medical benefits to longer than ten days. It is to be attached to a standard group contract, or with modified wording, to the surgical–maternity contract.
3. A contract adapting the surgical - maternity contract to those leaving group employment but desiring to continue the coverage. This may only involve a change in rates.
4. Riders for home and office surgery to be applied to any of the regular group contracts.

Physicians are requested to watch the special Blue Shield page in coming issues of the Wisconsin Medical Journal for details of each of the five existing contracts and any new developments.

World Medical Assn. Meets in New York

New York, Oct. 28.—Five hundred medical leaders representing 28 nations of the world gathered in New York recently to discuss problems of the medical profession and hear reports on medical progress.

The occasion was the 4th General Assembly of the World Medical Association, a voluntary organization of nearly 500,000 doctors in 41 countries.

Dr. Elmer L. Henderson, Louisville, Ky., president of the AMA, was elected president of the WMA at this the first WMA meeting in U. S. A.

Russia has never been represented in the WMA. Soviet bloc countries have been represented but all have either withdrawn or do not send delegates.

Delegates heard reports of dissatisfaction with the British medical scheme, and went on record as opposing any kind of euthanasia and "crimes against humanity" such occurred in Germany. They also denounced attempts "by various governments" to use biology, genetics, anthropology and physiology to serve political ends.

FREE BOOKLETS ON POISON COMPOUNDS

Madison, Nov. 1.—The committee on pesticides of the AMA is offering a series of reports to physicians free of charge which will be valuable to them in recognizing and overcoming the difficulties which certain of the newer compounds present.

It is studying insecticides, rodenticides, fungicides, herbicides and similar types of economic poisons. The first report is entitled "The Pharmacology and Toxicology of Certain Organic Phosphorus Insecticides."

Free copies may be obtained by writing the State Medical Society of Wisconsin, 704 East Gorham Street, Madison, Wisconsin.

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Set Up Rules for Assignment and Rank of Medical Men Registered Under P.L. 779

Washington, D. C., Oct. 23.—Controls governing the distribution among the services and determination of rank of medical personnel registered under the provisions of Public Law 779 have been announced by the Department of Defense.

In a release dated October 23, 1950, the department declared that physicians registered in Priority I (ASTP or V-12 trained men with less than 90 days service) will be offered appointments as reserve officers in the service of their choice **only** if they apply for commissions prior to their pre-induction physical examination, and are ordered to active duty at the time of their appointment.

Physicians who served during World War II in a rank higher than that for which they are now professionally qualified may be appointed as reserve officers in their former grade, with a waiver of professional qualifications.

Maximum age can be exceeded by an individual with prior service in the armed forces up to the number of years required to meet the years of professional experience.

Appointment of Priority I physicians, who request commissions and report for pre-induction physical examination, will be effected as follows:

If Total Number is	Departmental Allocation Army	Air Force	Navy
0–1000	98%	1%	1%
1001–2000	80%	19%	1%
2001–3000	80%	19%	1%
3001–4000	75%	24%	1%
4001–5000	70%	20%	10%
5001–6000	70%	20%	10%

The new regulations provide for the determination of rank for physicians on the basis of years of experience thus:

Minimum Years' Experience (Exclusive of internship)	Army and Air Force Grade	Navy Grade	Maximum Age
0	1st Lt.	Lt. (JG)	33½
3	Captain	Lt.	39½
10	Major	Lt. Cdr.	48
17	Lt. Col.	Cdr.	50

UNIVERSAL DONORS BEST IN DISASTER; ADVISE AGAINST MASS BLOOD TYPING

Madison, Oct. 14.—Mass blood typing of the general population, such as defense authorities are suggesting in Madison and Chicago, is "inadvisable for technical reasons," an editorial of the October 14, 1950, issue of the American Medical Association Journal declares.

The editorial asserts that "after consultation with various advisors, the Committee on Blood Banks of the AMA concluded that mass typing of the general population is inadvisable for technical reasons, including that of hazards to the patient introduced by dependence on such typing." Dr. W. D. Stovall, Madison, is a member of that committee.

"Previous experiences in mass typing have been disturbing rather than reassuring," the editorial continues.

"On the advice of federal officials, the committee stressed the importance of increasing the production of blood substitutes as well as whole blood in the present emergency," the editorial said.

Defense officials in Chicago and Madison are suggesting that all persons be blood typed and the type stenciled on the bottom of a foot or on the left chest wall.

The president of the American Association of Blood Banks, Dr. Thomas H. Seldon, director of the blood bank for Mayo Clinic, declared in Chicago on October 12, that "I myself would not rely in a transfusion on a typing determined by someone completely unknown to me. Many blood banks will not accept the typing even of another blood bank."

"In case of mass disaster, volunteer donors could be typed in 10 minutes and so-called universal donors possessing type O blood could be used exclusively. Victims would not need to be typed if O blood were being given."

Army Gives Priority to Reserve Applicants

Navy Clamps Down on Its Reservists

Washington, D. C., Oct. 24.—Although Army has stated that it will offer reserve commissions to all men in draft-eligible categories at the time of their physical examination and will do everything possible to assure qualified applicants of a reserve commission prior to induction, Navy has clamped down on its reserve commission policy.

That is the word from the AMA's Washington office.

Navy Calls Its Own

No former ASTP with less than 21 months active duty will be accepted by Navy. Former V-12s and those deferred to continue their education at their own expense during World War II may still volunteer for Navy reserves.

Navy says it will continue to call to duty V-12s in its unorganized reserves as well as reserves in organized units that are called to duty with their units.

Navy Loans to Army

However, next January, when Navy gets back its 570 V-12 reserves now on loan to Army, these doctors will remain on duty with Navy to replace older reserves with World War II service. The more experienced reserves will be released on the basis of amount of time spent in service in the last war.

Doctors Join Air Force

The 922 men Army has requested from Selective Service will merely replace the 570 Navy men on Army duty and 300 reserves Army called up on mandatory orders. The reserves will be returned to civilian life and the Navy men will go to active duty with their own branch.

Air Force, which has very limited reserve strength, reports it has commissioned 500 volunteers since August 1, and is now processing another 300 doctors. Most of these come from draft-eligible sources. Neither Air Force nor Navy has asked Selective Service to supply men for their services.

M.D.s May Apply for Commissions Up to Date of Induction

Washington, D. C., Oct. 31.—Regulations issued by the Defense Department and Army and a policy statement of Dr. Howard A. Rusk, chairman of the national advisory board on the doctor-draft, are clearing some of the confusion relative to recent Selective Service registrants.

Dr. Rusk says that registrants making application for reserve commissions up to the time they actually are inducted will be eligible for the $100 pay bonus, when and if the commission finally is granted.

However, if they delay application until after induction, the $100 monthly bonus is denied. Under Dr. Rusk's interpretation, a registrant may apply for a commission even during the 21 day period between notice to report for induction and induction.

A Navy spokesman concurred in this policy. But the Army Surgeon General's Office states that men will not be granted Army commissions during this 21 day period.

VETERANS OF 1898 GET VA BENEFITS

Madison, Nov. 1.—Veterans of the Spanish–American War, Boxer Rebellion and Philippine Insurrection are now eligible for outpatient medical care without regard to service–connection, according to word from the Veterans Administration.

Mr. T. J. Doran, director of the Wisconsin Veterans Medical Service Agency of the state medical society, has been advised of this new policy by J. P. Cullen, Wisconsin regional manager of the VA.

To be eligible, Cullen explained, a veteran must have served some time between April 21, 1898, and July 4, 1902 (or July 15, 1903, if the service was in Moro Province, Philippine Islands), and was discharged other than dishonorably.

It is estimated that there are approximately 1,700 living veterans in Wisconsin who have become potentially eligible by this ruling for full medical and dental care in VA clinics or at home by fee-basis physicians and dentists for any illness or disability.

Provide for Orderly Call-up of Reserves

Washington, D. C., Oct. 31.—Defense Secretary Marshall has issued directives for more orderly call-up of reserves which may have considerable effect on physicians.

Each service is to determine its requirements and make requisitions six months in advance of recall. Lists of all reservists are to be screened, and men judged to be in line for recall are to be notified. Reserves not placed on the ready-to-go list will not be notified personally, but the fact that they receive no word is evidence they will not be called for at least four months.

Men placed on the list, and so notified, are assured 30 days between orders to report for duty and date of reporting.

General Marshall also issued orders designed to clear up the status of men already on active duty under involuntary orders. He told Army, Navy and Air Force to keep such reserves on active duty until Selective Service or voluntary methods are able to supply replacements and individuals and units have "reached a maximum state of training."

Dr. Sargent on Board to Advise Selective Service

Chicago, October 9.—Procurement and assignment activity under the doctor-draft law will be handled by a committee of the National Security Resources Board, headed by Dr. Howard Rusk. Included on the committee are two members of the American Medical Association's Council on National Emergency Medical Service, Dr. James C. Sargent, Milwaukee, Chairman, and Dr. H. S. Diehl.

Blue Cross—Blue Shield Set Up Military Program

Milwaukee, October 10.—The Blue Cross and Blue Shield plans in Wisconsin have announced the establishment of a military program for those subscribers who are entering military service.

The two plans are making these special arrangements in order to cooperate as fully as possible with National Defense measures.

The program provides:

1. **Lowered rates for those with family contracts.**
2. **Continuation of existing benefits for dependents.**
3. **Suspension of membership for husband or wife entering services for the duration of his or her military service.**
4. **Reinstatement privileges within 60 days of discharge.**

Standard or comprehensive Blue Cross coverage has been lowered considerably for the family with either husband or wife in service.

New Rates Set

Wisconsin Physicians Service, the Blue Shield agency of the State Medical Society of Wisconsin, reports that its surgical-medical procedures plan has been reduced from $2.50 to $1.90 per month for such families. The surgical-medical contract under the Wisconsin Physicians Service has been reduced from $2.25 to $1.76 per month.

Those who are entering service may avail themselves of either or both of these provisions by contacting their Blue Cross-Blue Shield group leader or writing Wisconsin Physicians Service at 704 East Gorham Street, Madison, Wisconsin.

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INDUSTRIAL HEALTH CLINICS SET NATIONAL PATTERN

Dairyland State First to Try In-Plant Training of Doctors and Nurses

Madison, Nov. 1.—Wisconsin is known as America's Dairyland. Yet nearly half a million workers are employed by 7,000 light and heavy industrial plants. It is a rare city that does not have some type of industry within its limits. As a result, a certain amount of occupational disease and industrial accidents occur.

And that is the reason that the industrial health committee of the state medical society and the industrial hygiene division of the state board of health have really been "doing things" for doctors and industry.

Those efforts received national recognition last month when the Industrial Hygiene Newsletter, a magazine of the Public Health Service of the Federal Security Agency, devoted its entire October issue to the Wisconsin industrial health program.

In 16 pages of articles and pictures prepared by the state medical society and the state board of health, the nation learned how a new approach to medical education in Wisconsin—the "in-plant industrial health clinics"—is leading to better health for workers, more competent medical care for industrial cases and improved understanding between doctors, labor and management.

An article by Dr. D. E. Dorchester, Sturgeon Bay, chairman of the medical society's committee on industrial health, explained the program.

It is based on the philosophy that a good physician must know something about the environment in which his patients work if he is to do a top-notch job of diagnosing and treating patients whose health has been affected by their vocational activity.

Dr. Dorchester explained that the "open panel" system operated by the state medical society in connection with workmen's compensation gives the workers in most state industries complete free choice of physician for treatment when his health is affected by factors related to his job.

Wide acceptance of the program by employers and employes brought with it, however, more responsibilities on the part of the doctors whose names are listed on the panels.

DR. D. E. DORCHESTER

Most doctors, except full-time industrial specialists, are too busy with office calls, hospital rounds and home visits to spend much time in industrial plants learning how industrial work affects their patients' health.

During World War II, with defense production going full blast even in small communities, the industrial health committee and the state board of health stepped-up their educational program in the industrial health field. But it was the same old thing—didactic lectures in hotels, far from the noise, fumes and excitement of an industrial plant.

By the fall of 1947 it was apparent that a new approach was needed. Stepping out boldly, Dr. Dorchester's committee recommended clinics in the factories so that doctors and industrial nurses could rub shoulders with labor and management. They could see first-hand how industry is controlling some hazards, and how injuries still occur in spite of all precautions.

Says Dr. Dorchester, "The idea of having doctors and nurses meet together was radical enough, but to hold clinics right in the plants seemed impractical to many doctors."

The first three clinics were held in a paper mill, a foundry and a farm equipment plant. The results were startling even to the optimistic.

Instead of a handful of physicians as was anticipated, each clinic attracted nearly 100 doctors and nearly as many industrial nurses.

Since then in-plant clinics have been held in most parts of the state. More than 1,000 physicians have attended and the majority of industrial nurses in the state take part each year.

As a result, industrial health becomes not just the concern of a limited number of physicians known as "industrial specialists."

"Every physician in an industrialized community has a responsibility to know what is going on in the plants which employ his patients," wrote Dr. Dorchester. "If he is to serve them intelligently, it is to his interest to know more about the physical requirements of the work being done by his patients."

The in-plant clinic is one way in which doctors can acquire that knowledge. The dramatic appeal of the programs brings doctors and nurses into better contact and understanding. They assure management that doctors are really interested in what is going on in industry. They mean better health for workers.

Industry Plays "Ostrich" with Noise, Charge

Milwaukee, Oct. 4.—Industrial leaders and insurance companies have been charged with "playing ostrich" on the problem of noise deafness among industrial workers.

Dr. Meyer S. Fox, Milwaukee, told doctors attending the scientific sessions of the annual meeting that doctors see many patients who are entitled to industrial compensation because of permanent hearing damage caused by a noisy job.

Fear Claims Rush

He said that industry and insurance companies shy away from investigating the extent of the problem "for fear of stirring up claims."

He advocated precautionary safety orders on noise, and the redesigning and planning of tools and machinery to eliminate noise at its source.

TOP RATINGS STILL OPEN IN AIR FORCE

Madison, Oct. 10.—Excellent opportunities are available to young physicians who apply for commissions in the regular Air Force or the Air Force reserves, according to Maj. Gen. Harry Armstrong, surgeon general of the Air Force.

In a letter reviewed by the state medical society's committee on military medical service, Dr. Armstrong pointed out that all physicians and surgeons are commissioned in the Air Force at least as first lieutenants.

Ordinarily those with 3 years professional practice in civilian life can be commissioned as captains; 10 years practice qualifies one for a majority, and 17 years civilian practice entitles one to a commissioned rank of lieutenant colonel.

An Air Force officers cash income, including both pay and allowances, ranges from $4,300 to $8,600 for single officers and from $4,430 to $8,785 for married officers. This does not include the $100 per month bonus available to volunteers or officers called from reserves.

The Air Force also offers well-established graduate professional training programs and courses.

Full information can be obtained from United States Air Force, Office of the Surgeon General, Washington 25, D.C.

Consultation Needed on All Ceasarians, Delegates Rule

Milwaukee, October 4.—Doctors and hospitals throughout Wisconsin were requested by the state medical Society's House of Delegates to give special attention to the method of caring for mothers and babies popularly known as "rooming-in."

The recommendation was adopted by the House from a report of the committee on Maternal and Child Welfare, Dr. L. M. Simonson, Sheboygan, chairman.

Doctors and hospitals were asked to investigate the feasibility of placing the very young infant in the hospital room with the mother immediately after birth rather than in a centrally located nursery.

The House also took note of the high rate of caesarian operations being done in some parts of the state. It recommended that this type of surgery be resorted to only after consultation between two or more doctors.

This action was an indication of the delegate's belief in the age-old theory that two heads are better than one. The House expressed its firm belief that the judgment of more than one medical authority should prevail in cases of complicated pregnancy.

Outlook is Good for More Doctor Graduates

Chicago, October 1.—The outlook for graduation of more doctors to safeguard the health of the American people is better than it has ever been.

This was brought out in the annual report of the American Medical Association's Council on Medical Education and Hospitals.

All records for enrollment in approved medical schools in the United States were broken in the past year according to Dr. Donald G. Anderson, secretary of the council. Total enrollment in the 72 medical and seven basic science schools for the academic year 1949–1950 was 25,103. This represents an increase of 1,433 students over the preceding year.

In the last year, 5,553 physicians were graduated from approved medical schools in the United States, an increase of 459 over the preceding year. Medical schools estimate they will have slightly more than 6,000 graduates during the coming year.

Polls taken in 19 medical schools in the past year reveal that 47 per cent of the students plan on entering general practice. The number planning to specialize decreased from 36 to 31 per cent in the last three years.

CLINIC MANAGERS CONFERENCE at the annual meeting of the State Medical Society Oct. 3–5. Those who attended were (left to right seated) Harold Wruck, Shawano, Cantwell–Peterson Clinic; Frank Collins, Marinette Clinic; Harold Scherer, Monroe Clinic; Carroll Harris, Richland Center, Pippin Clinic; Neil Bingham, Janesville, Pember–Nuzum Clinic; Glen E. Visgar, Beloit Clinic; Arthur Goetz, Janesville, Koch–Munn Clinic; and William B. Wilcox, River Falls Clinic. Standing left to right are Mrs. Julia Loegerquist, Sturgeon Bay, Dorchester–Beck Clinic; Florence Simonson, Superior, Geisen Clinic; Arthur Gullickson, Madison, Dean Clinic; Clayton M. Bond, Sheboygan Clinic; Floyd Detert, Marshfield Clinic; H. R. Heberlein, Madison, Jackson Clinic, and M. J. Leinenkugel, Eau Claire, Midelfart Clinic.

Surgeons' Group Won't Give Up Hospital Standards Program

Chicago, Nov. 1.—The American College of Surgeons has announced that it will continue its program in the field of hospital standardization.

This follows a decision made last August by the American Hospital Association that it would conduct a hospital standardization program of its own. Apparently the hospital association action was taken in the belief that the college of surgeons was withdrawing from that field.

The regents of the college of surgeons voted unanimously on October 21 to continue the hospital standardization program of the college, according to a release.

"A spokesman for the regents stated that this action does not necessarily preclude consideration of proposals for the participation of other interested agencies in this program, but does make it clear that the American College of Surgeons has an undiminished interest in it and will consider no proposal which will not insure its continuation in the best interests of the public."

When the hospital association announced its intention of taking over this project last August, the American Medical Association immediately raised objections. At the October annual meeting of the State Medical Society of Wisconsin the House of Delegates passed a resolution condemning the hospital action as unwise and dangerous.

15 Counties Taking Part in Blood Program

Madison, Oct. 30.—Fifteen southern Wisconsin counties are currently participating in the blood program operated through the regional Red Cross blood center in Madison, according to Mrs. L. S. Davies, executive secretary.

These are Adams, Columbia, Dane, Dodge, Fond du Lac, Iowa, Jefferson, Juneau, La Crosse, Marquette, Richland, Sauk, Vernon, Walworth and Winnebago. Only Neenah and Menasha participate in Winnebago county, she said.

Grant and Monroe counties and the Beloit chapter of the Red Cross in Rock county are expected to join the program soon.

Dr. Lull Urges Truman to Fire Oscar Ewing

Chicago, Oct. 15.—The American Medical Association, in a blistering indictment of Federal Security Administrator Oscar Ewing, characterized him as a "disappointed, embittered bureaucrat, who should be removed from office before he does further harm to the country."

Dr. George F. Lull, Chicago, general manager of the AMA, who issued the statement, declared:

"Mr. Ewing in a speech on September 28 before the American Jewish Congress, descended to the depths of political demagoguery when he falsely implied that the AMA was practicing discrimination against Jews.

"He has long been a fomenter of class hatreds and he is now attempting to incite religious and racial hatreds in the manner of Hitler's Germany.

"Mr. Ewing is a case of arrested political development and his irrational statements undoubtedly are a consequence of thwarted ambitions and a growing persecution complex. He is wholly unfit for public office.

"The two Houses of Congress, in successive years, have given Mr. Ewing a decisive vote of 'no confidence' by rejecting his attempts to gain Cabinet stature and control over the medical profession through the creation of a Department of Health, Education and Security.

"President Truman should finish the job and dismiss Mr. Ewing from the public service before he does further harm to the country."

ILLINOIS PICKS DOCTOR OF YEAR

Monmouth, Ill., Oct. 30.—Dr. Ernest E. Davis of Avon, Ill., has been named outstanding general practitioner of 1951 by a secret committee of the Illinois State Medical Society.

He was selected from a score of entries submitted by the 91 county medical societies in the state. Dr. Davis' name will be submitted to the AMA delegates at the 1950 interim meeting in Cleveland Dec. 5–8, for consideration for the similar national honor.

The national honor was won last year by Dr. Andy Hall of Mt. Vernon, Ill.

Luther Hospital Opposes Compulsory Insurance

Eau Claire, Oct. 17.—The board of trustees of Luther Hospital in Eau Claire has adopted a resolution opposing compulsory health insurance, but urging "legislative attention" to the provision of aid for those unable to meet the whole cost of medical and hospital care.

Its resolution was similar to one adopted four months earlier by the Wisconsin Hospital Association, according to Mr. Nels Hanshus, superintendent of Luther hospital. The resolution stated:

"That the Board of Trustees of Luther Hospital does urge legislative attention to the provision of assistance for those unable to meet the whole cost of medical and hospital care, and for the provision of public health services, and for more adequate numbers of trained personnel in the health field, and, also,

"Now, therefore, be it further resolved, that after careful review and consideration, the Board of Trustees of Luther Hospital remains convinced that a program of compulsory health insurance is inadvisable and bound to be detrimental to the continuous improvement of the quality of care for the people of the United States."

The directors said that the resolution comes out of an appreciation of the need for a program "progressively improving and expanding hospital care."

Santa Claus, M.D. is New AMA Volume

Chicago, October 6.—Out of the welter of information on the nation's health, Dr. W. W. Bauer, of Chicago, director of the American Medical Association's Bureau of Health Education, has produced an authoritative and highly readable presentation of the doctor's case against compulsory health insurance.

Santa Claus, M.D., is written in simple language and amusing style. It presents expert testimony of the kind needed to make a decision for or against compulsory health insurance. Dr. Bauer detailed the American Medical Association's 12-point program for improving the nation's health and explained fully the value of the doctor's plans and programs.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D. University of Wisconsin Medical School, Madison

Presentation of a Case*

History.—An acutely ill, 23 year old white married woman was admitted to the Wisconsin General Hospital on June 10, 1944. History was obtained by an accompanying letter. For two months prior to admission the patient had had a generalized, ulcerative, purulent, draining, dermatologic lesion which also involved the mucous surfaces. Four weeks prior to admission the patient was treated for an old urinary infection with sulfonamides (the course of treatment and the exact drug were not given). Four days prior to admission the patient noted bleeding from the mouth for the first time. At the time of admission the patient complained of pain and respiratory distress.

Physical Examination.—Physical examination revealed a generalized purpura, involving particularly the ear lobes, fingertips, and toes. The neck, extensor surface of the arms, malar eminence, and forehead were involved by an erythematous scaly rash. The skin and sclerae had an icteric tint. There was a marked swelling of the neck, especially on the left, and bilateral lymphadenopathy. The left side was exquisitely tender. There was difficulty in swallowing and trismus. Numerous areas of bleeding and ecchymoses were present over the buccal surfaces. The right tonsil was covered by a purulent exudate, and marked edema of the left tonsil and an uvular deviation to the right were noted. The eyes showed ecchymosis and petechiae in the palpebral conjunctiva. The retina was edematous and contained small hemorrhages. The lungs were clear to auscultation and percussion. The heart was not enlarged. The pulse was 120 and the rhythm regular. The blood pressure was 110/70. The temperature on admission was 102 F. The abdomen was distended, the liver enlarged and tender. No record was made of splenic enlargement. A profuse, reddish brown, purulent discharge was emanating from the vagina.

Laboratory Data.—The hemoglobin content was 9.8 Gm., red blood cell count 3,230,000, and white blood cell count 14,300, with 88 per cent polymorphonuclear leukocytes and 12 per cent lymphocytes. No platelets were seen on the peripheral smear. The blood sugar content was 100 mg. per cent and nonprotein nitrogen 111 mg. per cent. The serology was negative. Smears from the pharynx showed a variety of organisms, including gram-positive streptococci and staphylococci. Cultures from the pharynx were positive for hemolytic streptococci (less than 10 colonies per plate). A blood culture showed no growth in 24 hours. The patient was blood type IV–O.

Therapy and Course.—The patient was given 4,000 cc. of 5 per cent glucose in water and 1,000 cc. of 5 per cent glucose in saline subcutaneously; 100 mg. of vitamin C; 500 cc. of whole blood and 20,000 units of penicillin every four hours. Early in the morning of the day after admission the patient went into shock-like state but responded to 1 cc. of coramine. Her condition, however, rapidly deteriorated, and the patient expired at 12:15 the day after admission.

Clinical Discussion

Doctor Rotter: With the information at hand, it would seem most logical to consider this in terms of a differential diagnosis of thrombocytopenic purpura. Thrombocytopenia, like anemia, is not a diagnosis but requires an explanation. It may best be classified as (1) the primary or essential variety; and (2) the secondary or symptomatic type. The first of these two would seem to be an unlikely possibility. The clinical course is not that of a true Werlhof's disease, which does not ordinarily run such a rapid downhill course and is practically never associated with fever and jaundice. The most common mode of exodus in the idiopathic thrombocytopenic purpura is intracranial bleeding, and the elevation of temperature and azotemia would be quite unusual. Actually, I think that idiopathic thrombocytopenic purpura is not a probable diagnosis unless we assumed, of course, that the situation were complicated by some septic process.

There are many causes for the secondary or symptomatic type of thrombocytopenic purpura. Certain chemicals, for example, are commonly incriminated in this regard. The organic arsenicals plus gold, benzol, and sedormid have been correlated with thrombocytopenia. No history of the use of these medications is presented, although we are told that the patient was treated with some sulfonamide preparation four weeks before she entered the hospital. Sulfonamides may produce thrombocytopenic purpura, but this toxic reaction is rare. To explain the entire picture we would also have to assume other targets for the sulfonamide toxicity: for example, the production of a hemolytic anemia, damage of the renal tubules associated with nitrogen retention, and possibly also a rash due to sulfonamides. Actually, from the protocol, it would appear that this patient's illness began before she was given any sulfonamide drug and, therefore, one would be hard

* From the State of Wisconsin General Hospital and University of Wisconsin Medical School.

put to incriminate this drug. Certain physical agents such as roentgen rays, radium, and burns may produce thrombocytopenia, but apparently these agents were not present; and, furthermore, one would expect an associated leukopenia in such cases.

A low platelet count associated with purpura may represent only part of an extensive involvement of the hemopoietic system. Acute leukemia, for example, may run a similar course, characterized by fever, cachectic state, often ulcerations in the mouth as well as lymph nodes, and hepatic involvement. However, usually in such cases the anemia is more severe than one might expect from just bleeding alone. Jaundice is not too common, and one would expect splenomegaly. Furthermore, the fact that no immature cells were reported in the blood smear would be a strong point against this diagnosis; one would expect a good many blast cells in the peripheral blood if this were acute leukemia. In aplastic anemia, thrombocytopenic purpura is accompanied by a pronounced leukopenia, as well as a relative lymphocytosis, and here again the anemia is more severe than the history of hemorrhage leads one to believe. In obscure cases of purpura, bone marrow replacement of myelophthisic anemia may be the cause, whether primary as in multiple myeloma or secondary due to bone marrow metastasis from carcinoma at another site. Myeloma would seem to be an unlikely possibility in the absence of marked bone pain and in view of the very rapid downhill course; and metastatic carcinoma in this age group would certainly be a rarity, although not impossible. From the physical examination we are given no findings to suggest abnormalities in the organs from which carcinoma frequently metastasizes to bone, such as breast, thyroid, lung, and kidney. It would be very unlikely for pernicious anemia to produce purpura, although frequently the platelets are reduced. One would also expect a reduction in white cells and a macrocytic anemia, both of which features were absent. Actually in any case in which a myelophthisic anemia is suspected, a bone marrow aspiration is an essential diagnostic procedure and certainly would have been of great help in establishing a diagnosis here.

Thrombocytopenic purpura has been described in a number of diseases in which the spleen is primarily involved, such as Gaucher's disease, Banti's syndrome, and hemolytic jaundice. In all of these conditions, however, the spleen is greatly enlarged, and there are frequently other characteristic signs to distinguish them. Much of this picture fits with the diagnosis of Hodgkin's disease; for example, the presence of lymphadenopathy, fever, hepatomegaly, and anemia. The presence of thrombocytopenia is a strong point against this diagnosis, however, since typically in Hodgkin's disease the platelets are normal or increased. One would have to presume that the Hodgkin's disease was of the sarcomatous variety and that there was extensive marrow invasion in order to produce this picture. This is, therefore, quite a remote possibility.

That purpura may be associated with certain febrile diseases is well known. Actually this patient's illness began with purulent skin lesions, and subsequently a febrile course and leukocytosis developed. It is known that some infection was present, since the patient had a positive throat culture for beta hemolytic streptococci, but it would have to be assumed that there was a severe septicemia to reproduce the entire clinical picture. Jaundice may be explained on the basis of liver abscesses and uremia associated with abscesses of the kidney. However, we are furnished the information that a blood culture was negative and, although this is not absolute, it would seem to be a strong point against a septicemic process. Bacterial endocarditis is a very remote possibility and would probably have to be of an acute variety to reproduce the symptomatology. One would expect more changes in the heart on physical examination and possibly also some splenomegaly, but we are not supplied with this information. Acute miliary tuberculosis has been reported to be associated with thrombocytopenic purpura, but here again one might expect some pulmonary change. Other infectious diseases associated with thrombocytopenia and purpura are typhus fever, smallpox, measles, scarlet fever, and typhoid fever; these possibilities seem very remote. Thrombocytopenic purpura has been noted in cases of lupus erythematosus, and much of the history suggests this illness. The protocol states that the patient had a scaly erythematous rash involving the malar areas, some lymphadenopathy, fever, and anemia. Much more typical, however, than thrombocytopenia in disseminated lupus erythematous is leukopenia, and there is frequently an associated splenomegaly. Furthermore, one would expect more involvement of the mesothelial surfaces and some arthralgia, which apparently this patient did not have.

There is a condition which was described initially in 1925 by Moschkowitz as a pathologic entity characterized by an acute febrile anemia with hyaline thrombosis of the terminal arterioles and capillaries. Since that time over 20 such cases have been reported in medical literature, and in 1947 the clinical and laboratory characteristics of this disease were established and the condition was named thrombotic thrombocytopenic purpura by Karl Singer of Chicago. Pathologically the disease is characterized by innumerable thrombi, consisting mainly of platelets and some fibrin, and located in the capillaries, arterioles, and in the smaller arteries. It has been claimed by some that there is a consummation of platelets in the formation of these thrombi, but the reason why this should occur is not clear. The clinical pattern is that of an acute febrile disease, characterized by the presence of petechiae and ecchymoses, thrombocytopenia, a severe anemia that is often out of proportion to the observed blood loss, mild acholuric jaundice, hepatosplenomegaly, and transient mental and neurologic symptoms and signs. Typically there is a leukocytosis and often, at least during some course of the illness, a leuke-

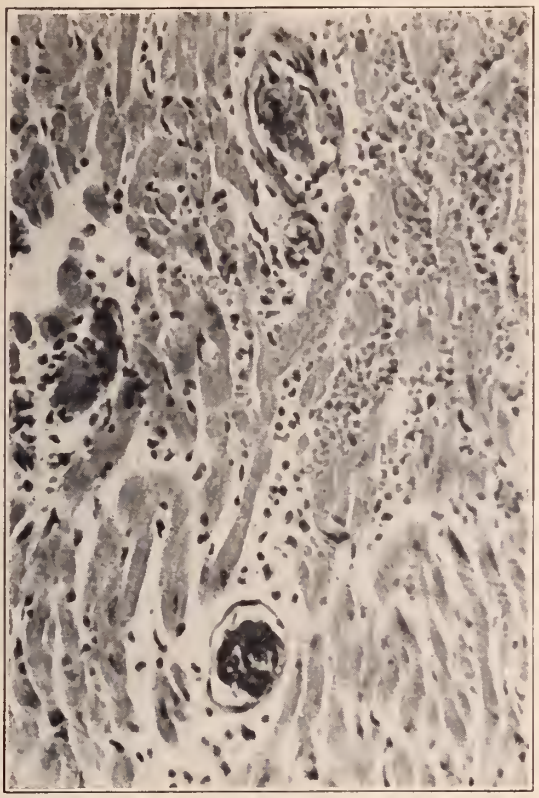

Figure 1

moid reaction. I have seen one such case which was diagnosed antemortem and proved at autopsy, and I must confess that the clinical features were similar to those presented in this protocol. More laboratory studies would certainly have been helpful, including a bone marrow aspiration, a Van den Berg reaction, a determination of urobilinogen in the urine, a reticulocyte count, and differential fragility tests. Since the patient was observed in the hospital for such a short time, obviously these were impossible to perform.

Of all the possibilities, I would favor thrombotic thrombocytopenic purpura as number one, with reservation only for a severe septicemic process with multiple visceral abscesses and secondary thrombocytopenic purpura.

Necropsy Findings

Doctor Altshuler: The gross examination of the patient at autopsy was not distinctive except for the widespread petechial and suffusive hemorrhages and jaundice.

The microscopic examination of the heart (fig. 1), liver, adrenals, and kidney revealed multiple arteriolar and capillary thrombi of the type seen in thrombotic thrombocytopenic purpura. Although foci of ischemic necrosis were occasionally present, they seemed disproportionately small. Reactive endothelial hyperplasia was not uncommonly observed.

The mechanism involved in the pathogenesis of the thrombotic lesion is obscure. Particularly, the significance of the endothelial hyperplasia is not known.

Our diagnosis, then, is thrombotic thrombocytopenic purpura.

CHEST PHYSICIANS AND GENERAL PRACTITIONERS TO PRESENT POSTGRADUATE COURSE

A postgraduate course in diseases of the chest for the general practitioner will be presented by the American College of Chest Physicians and the Milwaukee Chapter of the American Academy of General Practice during April 1951. The course will be presented on four consecutive Wednesday afternoons at the auditorium of the Milwaukee Children's Hospital in Milwaukee.

Subject material will cover all practical aspects of etiology, diagnosis, clinical management, and treatment of diseases of the chest by recognized authorities. Speakers are chosen both from the state of Wisconsin and from the country at large, and the program is outstanding in subject matter as well as in medical personalities. Complete details will be published in the near future. The course and curriculum have been officially approved by the Wisconsin Chapter of the American Academy of General Practice as an accredited course in postgraduate education for its members. Enrollment will be limited to 85 applicants. The fee for the entire course is $25.00, and will be used to defray traveling expenses for out-of-town speakers and administrative details.

Mischa J. Lustok, M. D., is the general chairman for the program and is arranging the curriculum and speakers' panel. Donald C. Ausman, M. D., secretary of the Milwaukee Chapter of the American Academy of General Practice, is also the secretary for the course, and all communications should be addressed to him at 2524 West Keefe Avenue, Milwaukee 6, Wisconsin.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

A question frequently asked of a public health physician at county medical meetings is whether the continual day by day care and treatment of his patients in the general practice of medicine isn't doing enough to promote a good community health program? The answer, of course, is an emphatic "No! !" The family physician must work with others in the community to preserve and improve local health conditions.

It is good public relations for doctors to let the people know about the physicians' interest in preventing disease. Clean environment, safe water, and grade A pasteurized milk all help to prevent the occurrence and spread of communicable diseases. The doctor's practice includes the treatment of these preventable diseases, but in some instances it takes other technical and trained people to "*prescribe*" for the treatment of environmental conditions. For example, a safe water supply, a grade A pasteurized milk supply, an adequate sewage treatment plant, and good housing help to prevent the spread of disease and death if they are controlled locally. Naturally, the general physician cannot be asked to take the time to do the intensive work which is necessary for preventing *all* diseases, so he calls upon the assistance of the public health personnel—public health nurses, engineers, and other trained citizens—to help him in his crusade for disease control.

The economics of selling medical service is no different from selling perishable food products. For both we attempt to supply the demand with an unquestionably good, wholesome, and healthy product. The producer must be aware of the public opinion concerning his product, and he must continually promote his good product and services and make every effort to correct deficiencies or inadequacies. In order to maintain good public relations the family physician must continue to do excellent work in the art and science of medicine and must not neglect or forget to help the public solve its community health problem.

The doctor may find it possible to serve as a responsible local health officer. He might find it possible to join local county groups, such as the county health committee which asks to have a doctor from the local medical society sit in on their meetings and advise them on matters of health. This activity promotes the best interests of the local medical society and helps to solve local health problems. At all times a physician should advise and assist in the formation of local public health councils and see that citizens consult recognized, qualified specialists in the multiphasic field of preventable diseases. A family doctor should meet with his local health council to present and discuss the merits of early diagnosis of preventable and degenerative diseases. The doctors should advise on the merits of using iodine to prevent goiter, the value of early immunization, and the value of early x-ray and skin tests in the diagnosis of tuberculosis. The diabetic surveys, the audiometric programs, and the vision-testing programs should be carried on by responsible citizens under the direction of the family physicians. In his community the doctor should make time for membership in one of the local health councils, or in some voluntary health agency such as the local poliomyelitis group, the local tuberculosis association, the local cancer society, or the local association for crippled children. It is necessary for the doctor to discuss sensible health programs with lay members of his council. The informed public is more apt to supply hospital beds, better diagnostic equipment, and better facilities if these needs are discussed in responsible local health councils.

At the present time the county medical society advises with local health authorities to provide annual immunization programs, tuberculosis bus miniature x-ray screening programs, audiometric testing programs, diabetic surveys, and the various preschool examination programs. These activities improve public relations and their private practices.

Good public relations is the answer for promoting our continually good medical service. Of the basic four—food, clothes, shelter, and health—health is recognized as the key stone to the arch of necessities in life. People are interested in health and newspapers are willing to print news about health. In one newspaper recently circulated in the southwestern part of Wisconsin, I found that approximately 12 full page-length columns were either directly or indirectly about health. The various articles ranged from the number of undetected diabetic patients in the country, as estimated by eminent medical authorities, and the highly popular subject of poliomyelitis victims to the question of grade A milk for interstate shipment and diseases spread among the animals which cause economic loss to the farmer. Local physicians should help to see that all this health information is accurately interpreted.

In summary, a district health officer at times finds himself advising local physicians on problems in public relations. He can give this service to family physicians interested in improving the health of their local communities.—PIERCE D. NELSON, M.D., *District Health Officer, District 1, Madison.*

. . . . THE PRESIDENT'S PAGE . . . .

Wisconsin Looks Ahead For the Mentally Ill

THE care of the mentally ill and the mentally deficient is a big problem confronting the public in every state in the union. Wisconsin has been extremely slow in providing adequate facilities for the care of the mentally ill over the past 40 years. Our state mental institutions have been allowed to deteriorate, and, of course, they were built 75 years ago or more, when buildings were not erected out of fire-proof material. They are, consequently, looked upon today as great fire hazards, which they truly are. The state has increased in population, while the bed capacity in our state institutions has remained stationary; consequently, a very crowded condition has resulted.

Thanks to Governor Rennebohm's administration, the Legislature has gone all-out on a building program during his time as Governor of the State. We now have one new building already erected and ready for occupancy at Oshkosh. A second building is to be erected at Oshkosh. The state has acquired the soldier's hospital at Mendota, which gave that institution an increased bed capacity of about 200. More buildings will be erected at Mendota, and the old fire hazard building will be remodeled. Union Grove, I understand, will be greatly expanded for the care of the mentally deficient. A diagnostic center will be erected in Madison. Money has been raised for this entire program, and I believe the governor expects to sign contracts for these structures before he leaves office.

I am impressed with the standard of care being provided in the Central State Hospital at Waupun. Dr. J. F. Klepfer, its superintendent, is largely responsible for a well kept institution, operated under a modern concept of responsibility to its inmates.

There has been a great deal of improvement in the care of the mentally ill in our county institutions during the past five years. Our new mental hygiene director, Dr. Leslie A. Osborne, informed me a few days ago that he has a further improved program for the care of the patients in the county institutions. When these various projects and programs are fully instituted, I believe that Wisconsin will stand out as the leading state in the union for the care of the mentally ill—thanks to Governor Rennebohm and the Legislature with which he has been working.

H. H. Christoffersen M.D.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Directing Board of Blue Shield of Wisconsin, an Agency of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

[Blue Shield of Wisconsin presents this page as a monthly feature of the medical journal as a means of providing Wisconsin physicians with a better understanding of Blue Shield plan benefits, contract interpretations and administrative procedures. Blue Shield will be happy to answer on this page any questions and problems you may submit. No inquiries will be identified.]

What Is Blue Shield Of Wisconsin?

Blue Shield of Wisconsin (Wisconsin Physicians Service) was established by the House of Delegates in 1946 to provide surgical, obstetrical and medical insurance coverage for the people of this state. It operates as an agency of the State Medical Society of Wisconsin under a Directing Board of nine members nominated by the President and approved by the House of Delegates.

Current members of the Directing Board are: E. M. Dessloch, M. D., chairman, Prairie du Chien; Karl H. Doege, M. D., vice chairman, Marshfield; J. W. Truitt, M. D., Milwaukee; N. A. Hill, M. D., treasurer, Madison; Milton Finn, M. D., Superior; Rogers E. Garrison, M. D., Wisconsin Rapids; John T. Sprague, M. D., assistant treasurer, Madison; Paul B. Mason, M. D., Sheboygan; and W. C. Stewart, M. D., Kenosha.

In 1947 Wisconsin Physicians Service was accepted as a member of the national Blue Shield Commission (of which most state physicians service plans are members) and given the privilege of using the title "Blue Shield."

Why Is The Name "Wisconsin Physicians Service" Also Being Used?

Considerable time and effort are required to change the wording on contracts, stationery and promotional literature. More than 75,000 contracts were issued under the name of "Wisconsin Physicians Service." Thousands of pieces of literature bear this title. It would be costly, and almost impossible, to scrap or replace all contracts and literature immediately. Confusion will be eliminated if you remember that "Blue Shield of Wisconsin" and "Wisconsin Physicians Service" are one and the same organization.

How Are Blue Cross And Blue Shield Related?

Blue Cross is a non-profit corporation engaged in selling hospital insurance and providing hospital benefits. Blue Shield of Wisconsin is a non-profit agency of the State Medical Society providing benefits in the surgical-medical field. By agreement between the State Medical Society and Blue Cross in 1947, Blue Cross became the enrolling and billing agent for Blue Shield.

The Blue Cross sales force enrolls groups and individuals in Blue Shield and premiums are remitted by these groups or individuals through Blue Cross to the Blue Shield office. Physicians' claims for payment for services rendered Blue Shield subscribers should be submitted directly to Blue Shield. All claim adjustment for Blue Shield subscribers is done solely by Blue Shield.

Where Can One Get Information About Blue Shield?

Inquiries on claims, contract provisions and interpretation, and administrative procedures should go to Blue Shield of Wisconsin, 704 E. Gorham Street, Madison 3.

Potential subscribers and inquiries relating to benefits, premiums and enrollment can be referred to local or district Blue Cross-Blue Shield agents:

Robert Brownlee, Rice Lake; Ray McNair, Eau Claire; Milton McRae, Superior; Gene Kaster and Fred Beisel, Green Bay; Harry Melor, Wausau; Neil Sharkey, Biron; John Bronch and Frank H. Dillman, Fond du Lac; Gene Bartzen, Sheboygan; Aaron E. Dix, Neenah; Randall Schumann, Bill Schumann and Clifford Borchardt, Madison; Margaret B. Hull, R. N., La Crosse; Earl Schlender, Janesville; Leo Suycott, Milwaukee, manager of the southeast Milwaukee district including Kenosha and Racine; and Charles C. Hyink, Milwaukee, manager of the northwest Milwaukee district.

Blue Shield Coverage Increases

A total of 184,165 persons are covered by Blue Shield of Wisconsin as of August 31, 1950. Claims totaling $2,293,124.41 have been paid in the period from June 1946 to August 31, 1950.

Look For These Answers Next Month

What is meant by "Full Payment?"

What is "usual prenatal, delivery and postnatal care?"

What surgical services are included in a Blue Shield of Wisconsin contract?

When does maternity coverage begin? When does it end?

Minutes of the Council Meeting, Madison August 19-20, 1950

1. Call to Order

The Council was called to order by Chairman Arveson at 2:00 p.m., Saturday, August 19, 1950, at the Society's office, Madison.

2. Roll Call

Councilors present were Doctors Eck, Hemmingsen, Tenney, Kasten, Dessloch, Heidner, McCarey, Bell, Christofferson, Arveson, Howard, Wegmann, and Chairman Emeritus Gavin.

Also present were President Truitt; Speaker of the House Stewart; Delegate to the American Medical Association Stovall; Treasurer Sisk; Doctor Supernaw, chairman of the Veterans Medical Service Agency; Doctor Fitzgerald, chairman of the Committee on Grievances; Doctor Parkin, medical director; on Saturday, members of the Wisconsin Plan Committee, Doctors Krohn, Moore, Foregger, Aageson, Christianson, Reznichek, and Carlson; Mr. Carl Tiffany, consulting actuary; Mr. John Joanis, Hardware Mutuals Insurance Company; and Mr. John Rogers, Continental Casualty Company. On Sunday, Dr. M. W. Stuessy, chairman of the Committee on Rural Health and Accident Prevention; Dr. F. L. Weston, chairman of the Committee on Military Medical Service; and Dr. C. N. Neupert, state health officer, were present.

Also present at all sessions were Secretary Crownhart; Assistant Secretary Ragatz; Mr. Murphy, legal counsel; Mr. Weber, director of Wisconsin Physicians Service; Mr. Doran, director of the Veterans Agency; Mr. Thayer, director of public information; Miss Helen Brandt; and Mrs. Margaret Pharo, of the Society's office staff.

3. Report of the Committee on Grievances

Doctor Fitzgerald, chairman of the Committee on Grievances, reported that the committee had considered about fifty-six different complaints referred to it. A progress report on pending cases was outlined. No action by the Council was indicated.

4. Report of the Wisconsin Plan Committee

Dr. Robert Krohn, chairman of the Wisconsin Plan Committee, reported that all members of the Council had been presented with a detailed report on the Wisconsin Plan, outlining its development since October 1945. He stated that the Medical Society performs the following functions in promoting the plan:

a. Publishes an annual list of participating physicians.
b. Publishes a Questions and Answers pamphlet on the plan.
c. Publishes information in *The Wisconsin Medical Journal* periodically.
d. Publishes the full schedule of surgical benefits applicable to Wisconsin Physicians Service as well.

Doctor Parkin serves as medical advisor in claim administration, and Mr. Doran acts as claims administrator. At times, it is necessary to refer questions on claims to the Wisconsin Plan Committee, and when principles are involved which should also be considered by Wisconsin Physicians Service they are referred to the Coordinating Committee on Prepaid Health Plans.

Meetings of the Wisconsin Plan Committee are held at least quarterly, sometimes more often.

Twenty-two insurance companies have submitted their policies to the State Medical Society for approval, and they have been approved as meeting the specifications established by the Society.

Total enrollment as of June 30, 1950, was reported as 249,782.

Several hours were devoted to a full discussion of the details of the Wisconsin Plan, when the Council met in executive session. No action was recommended.

5. National Legislative Report

Dr. W. H. Huron of Iron Mountain, Michigan, was present for this item on the agenda. As legislative coordinator of the American Medical Association for the district of which Wisconsin is a part, he presented a report on national legislation.

The Council then recessed for dinner, and during the evening Mr. LeRoy Luberg, assistant vice president of academic affairs at the University of Wisconsin, spoke on problems of mutual concern in medicine and education.

The Council reconvened at 9:30 a. m., Sunday, August 20.

6. Report on Civilian Defense

Doctor Neupert reported that at the request of the National Security Resources Board, he had attended an orientation meeting in Chicago having to do with atomic energy in civil defense. His appointment to this capacity was made by the governor. He reported that blueprints were being developed for a uniform civil defense program throughout the country.

7. Life Membership—Dr. G. A. Steele, Oshkosh

Doctor Steele was licensed in 1910 and was elected to membership in that year. At the 1949 meeting of the House of Delegates the By-Laws regarding life membership were changed to provide that an active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status

of a life member, and if he accepts shall enjoy full membership privileges but shall be exempt from the payment of dues or assessments.

Doctor Steele had been a member for forty years instead of the required fifty years. In January or February of 1949 he made his fortieth payment of dues in contemplation of life membership. Therefore, question arose as to whether he could be considered qualified for life membership.

Following discussion, it was moved by Doctors Dessloch–Ekblad, carried, that life membership not be granted in this instance, as to make an exception in one case would justify further exceptions.

8. Committee on School Health Requests

The Committee on School Health was appointed by President Truitt to serve as an advisory committee to both the Department of Public Instruction and the State Board of Health in their activities in school health. The committee requested that it be given permanent status by being designated as a Council committee, rather than to be terminated at the end of the current year as a committee of the president.

In addition to five physician members, there were three ex-officio members whose association with the committee was determined by virtue of their positions. They were the director of public health nursing, State Board of Health; the health educator of the State Board of Health; and the health educator of the Department of Public Instruction. In addition, the state superintendent, Mr. Watson, served as an advisory member for one year. The committee requested that another ex-officio member be added, the health chairman of the Wisconsin Congress of Parents and Teachers, who is always a physician.

On motion of Doctors Christofferson–Tenney, carried, the requests of the Committee on School Health were approved.

9. Guest Speakers on Medical-Economic Topics

General discussion ensued with regard to this subject. No action was taken.

10. Report of Coordinating Committee on Prepaid Health Plans

Doctor Kasten, chairman of this committee, presented a detailed report of the committee's considerations and its recommendations. Specifically, the committee recommended the following:

a. Authorization of an Advisory Commission on Prepaid Health Plans in Wisconsin, formed of public membership.

b. If recommendation *a* is aprpoved, the Council return the proposal to the Coordinating Committee for complete development and for the submission of a further report to the Council relative to the method for the selection of such an Advisory Commission, as well as details relative to its functioning.

c. Consideration not be given at this time to the feasibility of collecting premiums of the Society's programs, based on payroll percentage; and affording opportunity for insured persons to extend benefits during periods of unemployment through advanced premium payment.

d. Instructing the committees in direction of Blue Shield and the Wisconsin Plan, that it was the intention of the Society that the entire income of eligible members of a family be considered in defining income levels under the Society's insurance programs, and that the income should not be divided as between those with individual coverage. If the Council approves, this action be reported to the House of Delegates.

On motion of Doctors Bell–Christofferson, carried, these recommendations were approved.

11. Committee on Military Medical Service

Doctor Weston, chairman of the committee, reported that the Committee on Military Medical Service was probably the first group in the state to approach the governor as to its willingness to cooperate in any of the emergency matters that might come as a result of serious state disaster. As a result, the committee prepared its plan for local county societies, or combinations of societies, to determine what facilities might be available to meet a disaster that might occur in their home group or in some adjoining territory. About twenty-five county societies informed the committee that committees on military or civilian disaster were set up to carry on with such a plan as the Committee on Military Medical Service might propose.

Further, the committee has been concerned with the problem of procurement of physicians. It felt the necessity of maintaining up-to-date and complete files on each physician in the State Society office.

Mr. Crownhart stated that it was increasingly apparent that procurement and assignment of physicians was virtually in effect. Selective Service had already contacted the office with reference to some problems in the state. The Council on National Emergency Medical Service of the American Medical Association had asked the Society to submit for referral to the federal government nominees of three physicians in order of selection, to take over the work in this particular field.

He pointed out that it was the recommendation of the officers and the Interim Committee that the personnel of the Committee on Military Medical Service, with Doctor Weston as chairman, be designated to the American Medical Association for handling of this work in the future.

On motion of Doctors Kasten-Eck, carried, this recommendation was approved.

12. Dues for Men in Service

Mr. Crownhart stated that some physicians had already gone into service from their reserve status, and county secretaries had inquired whether their dues would be waived as was done in World War II.

On motion of Doctors Bell–McCarey, carried, the Council authorized waiving dues of men in service, on a prorated basis.

13. Staff Privileges

Question had been presented to the Society's office as to how staff privileges should be stated. The Council's advice was sought as to what function the secretary's office should have in this matter.

On motion of Doctors Fox–Dessloch, carried, the secretary's office and legal counsel were asked to keep informed on progress in the case.

14. Rural Health Conference

Doctor Stuessy, chairman of the Rural Health Committee, stated that the committee, together with fifty-four other organizations had been preparing a Rural Health Conference to be held at Green Lake on September 22 and 23. Physician representation was asked, and approval to determine the value of the conference by asking for comments from those in attendance. Suggestions of the Council were also sought for ways and means of selecting a physician for the Country Practitioner Award.

Doctor Arveson, chairman of the Council, appointed Doctors Kasten, Christofferson, Eck, and Galasinski as representatives to attend the Rural Health Conference.

On motion of Doctors Bell–Fox, carried, the secretary's office was instructed to make biographic information available to the Executive Committee of the Rural Health Conference for the selection of a Country Practitioner of 1950.

15. Report of the Veterans Medical Service Agency

Doctor Supernaw, chairman of the Veterans Agency, presented the following report on the total value of business with the Veterans Administration from November 1, 1946 through August 15, 1950:

Total value of authorizations received from V. A.		$1,326,935.33
Total value of authorizations cancelled		110,001.90
Total value of unused authorities		183,760.01
Total value of claims filed with V.A.		1,053,247.69
Total cash disbursed to physicians	$946,985.80	
Total administrative expense received from V.A.	98,127.23	
Total cash received from V.A.		1,045,113.03

Doctor Supernaw further reported that 95 per cent of the postal card inquiries sent to veterans receiving treatment under the program had been returned, of which 98 per cent had been favorable to the treatment received, and satisfied with the relationship with the doctor.

The contract with the Veterans Administration was renewed as of May 26, 1950.

On motion of Doctors Dessloch–Ekblad, carried, the report of the Veterans Agency was approved.

16. Report of Spring and Industrial Health Clinics

Mr. Ragatz presented a report on the results of the Spring and Industrial Health Clinics, copies of which had been sent to the councilors previously. It was agreed that the substance of the report be presented to the House of Delegates through the Delegates Handbook.

17. Adjournment

The Council adjourned at 12:30 p.m.

C. H. Crownhart,
Secretary

Approved:
R. G. Arveson
Chairman of the Council

INDUSTRIAL HEALTH INSTITUTE OFFERS FELLOWSHIPS

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships which are being offered to qualified candidates who wish to pursue a graduate course of instruction which will qualify them for the practice of industrial medicine. Candidates who complete satisfactorily the course of study will be awarded the degree Doctor of Industrial Medicine. Any registered physician, who is a graduate of a class A medical school and who has completed satisfactorily two years of residency (including internship) in a hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health. The course of instruction consists of a two year period of intense preliminary training in the basic phases of industrial medicine followed by one year of practical experience under adequate supervision in industry. During the first two years, the stipends for the Fellowships vary from $2,100 to $3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training. Requests for additional information should be addressed to the Institute of Industrial Medicine, College of Medicine, Cincinnati 19, Ohio.

Minutes of the Council Meeting, Milwaukee, September 30 and October 1, 1950

1. Call to Order

The Council was called to order by Chairman Arveson at 5:00 p.m., Saturday, September 30, 1950. at the Hotel Schroeder, Parlor A, Milwaukee.

2. Roll Call

Councilors present were Doctors Eck, Hemmingsen, Tenney, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Christofferson, Arveson, Ekblad, Howard. Pierce, Wegmann, Leahy, Chairman Emeritus Gavin, and Past-President Doege.

Also present were President Truitt, Delegate to the American Medical Association Stovall; Dr. R. C. Parkin, medical director; Dr. R. E. Fitzgerald, chairman of Committee on Grievances; Dr Gunnar Gundersen, Board of Trustees of the American Medical Association; Dr. Frank Elias and Mr. R. R. Rosell of the Minnesota State Medical Association; and on Sunday, Dr. F. L. Weston, chairman of the Committee on Military Medical Service; Dr. J. H. Houghton, Wisconsin Dells; Speaker of the House Stewart; Treasurer Sisk; and members of the State Board of Health, Doctors Neupert, Jorris, Henke, Clark, Raine, Cahana, and Neidhold. Miss Eleanor Bauhs and Miss Lolita Maedke of the State Board staff were also present.

Others present were Secretary Crownhart; Assistant Secretary Ragatz; Mr. T. J. Doran, director of the Veterans Agency; Mr. Ralph Weber, director of Wisconsin Physicians Service; Mr. E. R. Thayer, director of public information; Mr. Robert Murphy, legal counsel; Miss Helen Brandt and Mrs. Margaret Pharo of the Society's office.

3. Oregon Trust Suit Settled

Secretary Crownhart informed the Council that a telegram had just been received from the Oregon State Medical Society to the effect that the government was defeated in all of its charges of anti-trust imposed against that Society.

On motion of Doctor Christofferson, variously seconded, and carried, the secretary was asked to send the Oregon Society a message of congratulations.

4. Approval of Minutes

On motion of Doctors Leahy–Howard, carried, the minutes of the June 3–4, 1950, Council meeting, as published in the August issue of *The Wisconsin Medical Journal*, were approved.

5. Special Report to the House of Delegates on Prepaid Plans

Secretary Crownhart stated that it had been suggested by members of the Council that, in view of the many resolutions on prepaid insurance, it would be wise and appropriate for the Council to file a statement with the House of Delegates on this function. The following statement had been drafted for the consideration of the Council:

"This special report of the Council is made by reason of the fact that it is charged with general direction and management of Society affairs when the House is not in session.

"With the phenomenal development of the State Society's two prepaid plans in Wisconsin, some concern has developed on the part of physicians with respect to details and technics of the programs. The Council feels that a brief résumé of this topic is in order.

"The Wisconsin Plan, written through private insurance carriers, was the first state-wide plan, followed closely by Blue Shield of Wisconsin (also known as Wisconsin Physicians Service). The latter is owned and operated by the State Medical Society itself.

"Both plans have the seal of approval of the American Medical Association; and both plans, in general, are considered to be serving the same purpose and utilize the same general method of doing so. They are characterized as 'combination service and cash indemnity' in the directory of plans issued by the American Medical Association.

"To a defined income bracket, participating physicians are pledged to make no additional charges. To those falling in a higher bracket, no such promise is made, so as to that group the plan amounts to indemnity insurance.

"The Blue Shield plans constitute the largest number of medically sponsored programs in the country. Not all of them are owned and operated by the organized profession. Not all of them contain the 'full payment' feature.

"There are a number of plans modeled after the Wisconsin Plan. It is reported that on January 1 such a program will be instituted in Georgia. Tennessee utilizes the identical features of the Wisconsin Plan, and Blue Cross participates in that program. In that state, it is reported that total coverage has now been extended 225,000 persons through eighteen private insurance carriers and the two Blue Cross plans existing in Tennessee.

"Similar efforts exist elsewhere, and among the most interesting is that in New Mexico where a nonprofit corporation (similar to Blue Shield of Wisconsin) has re-insured all contracts in a commercial insurance company.

"It must be conceded that the principle of prepaid health insurance is widely accepted by the public and the profession. In Wisconsin alone, the numbers covered by Blue Shield of Milwaukee, Blue Shield of Wisconsin, and the Wisconsin Plan amount

to nearly three-quarters of a million—and this is approximately four years of effort!

"It seems clear that the principal problem facing the profession and the public is perfection of those plans, for their value as an economic device in the preservation of systems of voluntary medical care is hardly subject to question at this point.

"In their perfection, there are two matters of importance. One is to construct the actual contract provisions so that conditions under which benefits may be obtained are not only clear, but eminently fair necessarily in conformity with basic insurance principles. The other phase of the programs has to do with the schedule of benefits.

"*1. Full payment to appropriate income level.*

Prepayment plans have three objectives: first, to provide a mechanism under which people may insure themselves against some of the costs of illness; second, to preserve as much independence to the economic status of medicine as is consistent with public duty and patient welfare; and third, to provide a *full payment feature for those in limited income groups, so that additional fees will not be necessitated.*

"*2. Fees provided are not fees for the average.*

Under full payment, the benefits allowed are *not* intended as average fees. One plan specifically so states.

If insurance of the character of Wisconsin Physicians Service (Blue Shield of Wisconsin) or the Wisconsin Plan is to provide average fees for the average case, then it would be pointless to have full payment limited to a specified income group. Full payment should then apply to any income level.

If that is done, the whole of the economics of the medical profession is governed by insurance concepts and mechanism.

If such results from voluntary insurance, its adaptability to compulsory mechanisms is readily apparent.

Blue Shield of Wisconsin and the Wisconsin Plan provide fees for persons of limited income

and

Substitute the liability of the plan for liability on the part of the individual or the family.

"*3. Extension of the voluntary insurance is dependent upon the public's purchasing power.*

The fees paid as benefits relate directly to the amount of premium paid. Use the following as an example:

Of every dollar paid physicians by Blue Shield of Wisconsin:

11.6 per cent is for tonsillectomies and adenoidectomies.
13.5 per cent is for appendectomies.
11.5 per cent is for deliveries.
53.4 per cent is for other procedures.

"If the benefits for the first three benefits are raised, there must be a corresponding increase in premiums. Such is the case in all other procedures in relationship to the perecentage paid for benefits.

"TO FIND OUT JUST WHAT THESE PERCENTAGES ARE, THE COUNCIL HAS EMPLOYED, THROUGH A SPECIAL COMMITTEE, A CONSULTING ACTUARY.

"The report of the actuary is expected shortly after the first of the year.

"The Council prior to that time will appoint, under the general direction of its special committee, a fee schedule committee representing the sixteen specialties now recognized, together with a representative of general practitioners. Each of the specialty groups as the general practitioners, through state organizations, will be asked to select, for Council confirmation, its member of the special fee schedule committee.

"Those seventeen men will be asked to consider the whole problem involved in the current fee schedules and, in particular, to report on one possible solution to some phases of the problem suggested as a schedule defining fees for some of the principal procedures, with non-enumerated procedures being compensated on the basis of '*usual and customary fee for patients in the defined income group.*' A maximum benefit would be required in the interest of the financial security of the plan.

"Advice made available to the Society indicates substantial points in favor of such a device, the major considerations being to (1) permit some latitude where unusual facts are encountered; (2) avoid innumerable problems of nomenclature; (3) minimize incomplete and unfair comparisons with schedules placing a high value on relatively rare procedures for competitive reasons; (4) eliminate complete regimentation to a uniform schedule for all procedures; and (5) avoid the present tendency to apply the schedule to those individuals either not within its full payments benefits, or not covered by insurance at all.

"At this point, the work of the actuary comes into play. The cost of the insurance is related to the number of procedures that may be contemplated in a large group, and the dollar valuation may then be actuarially determined.

"This is not a monumental task, but is one involving studious attention to detail, and proper evaluation of procedures.

"The Council intends, when this is completed, to call a special session of the House of Delegates, to review the work of the committee and to pass final judgment upon it.

"No other state medical association, to the best knowledge of the Council, has engaged in such a careful over-all study.

"It is the Council's recommendation that all matters pertaining to prepaid medical care plans be held over until the special session, and the report of the special committee as outlined in this report."

Following discussion, it was moved by Doctors Kasten–Fox, that the Council submit the statement to the House of Delegates for its consideration. The motion was carried with one dissenting vote.

6. Resolutions Commending Radio Stations, Newspapers, and Providing for Five-Men Committees Approved

The following three resolutions were submitted for Council approval:

a. *Commending Radio Stations Which Carry the "March of Medicine":*

WHEREAS, twenty-six radio stations in Wisconsin and Michigan have carried the radio program of the State Medical Society of Wisconsin known as the "March of Medicine" for periods from one to five years, and

WHEREAS, the generous giving of time and effort by these radio stations constitutes a a real community service, and an outstanding contribution to health education in Wisconsin,

Therefore Be it Resolved that the House of Delegates take special recognition of radio's part in educating people to better health practice, and commend the radio stations carrying the "March of Medicine" for their exceptional contribution to improve health for the people of this state.

b. *Commending Newspapers in Wisconsin:*

WHEREAS, the newspapers of Wisconsin are celebrating National Newspaper Week, October 1 to 8, with special emphasis on rededication to the ideal of a free press for a free people, and

WHEREAS, the daily and weekly papers of Wisconsin have throughout the past year performed outstanding service to the field of health education, and have increasingly provided the citizenry with factual information from both the scientific and economic aspects of medicine,

Therefore Be it Resolved, that the House of Delegates commend the newspapers of Wisconsin for exceptional contribution to the health of the people of the state, and urge them to hold fast to their belief that intelligent public opinion based on the facts and the truth will keep America free.

c. *Providing for a Minimum of Five-Men Committees Unless Otherwise Indicated in the By-Laws:*

Resolved that Chapter VII, Section 1 of the By-Laws be amended to read:

Unless otherwise provided in these By-Laws, each of these committees shall consist of *five* members, each of whom shall serve for a term of *five* years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, *four*, and *five* years, and thereafter for terms of *five* years each.

Resolved that inasmuch as the By-Laws with reference to some standing committees provide for three members, the following amendment be applied in these instances:

When membership of a committee is indicated as less than five members, the number be changed to five, with terms of five years each.

On motion of Doctors Fox–Ekblad, carried, the Council approved these three resolutions and asked that they be forwarded to the House of Delegates.

7. Study of Group Malpractice Insurance

President Truitt presented the following resolution for Council consideration, to be forwarded to the House of Delegates if so desired.

WHEREAS the Committee on Group Insurance initially recommended a study of group health and disability for the members of the State Medical Society, and

WHEREAS such a program is now established, and

WHEREAS the Committee on Group Insurance did such a commendable job in developing this program,

Therefore Be it Resolved that the Committee on Group Insurance in the coming year consider a program of group malpractice insurance for the members of the Society.

On motion of Doctors Dessloch–McCarey, carried, the Council approved submitting this resolution to the House of Delegates.

8. Supplementary Report of the Council to the House of Delegates

Several matters which had been considered by the Council were outlined in a proposed report to the House of Delegates. Actions taken were as follows:

a. *The Pharmacy Law.* The Council has cooperated with the Society's Grievance Committee and with the State Pharmaceutical Association in bringing to the attention of the membership certain basic provisions of the pharmacy law. There are matters yet to be settled.

Printed notices relating to the need of prescriptions to obtain certain dangerous and other drugs have been prepared and circulated by the Wisconsin Pharmaceutical Association, and have the approval of the Society.

Matters relating to the application of the law to the physician who finds it advisable to do his own dispensing are under careful consideration. The membership may expect further bulletins on the subject in the near future. The Council does emphasize the ramification of the subject. Rules applicable to physicians must be applicable to physicians generally, and what applies to physicians in private practice applies likewise to the availability of drugs in hospitals, convalescent homes, county and state institutions, and the like.

On motion of Doctors Bell–Tenney, carried, the Council approved this report and referred it to the House of Delegates.

b. *Advisory Commission—Prepaid Health Plans.* Some months ago the Council formally created a Committee on Coordination of Prepaid Health Care Plans. That committee consists of the president of the Society; the chairmen of Blue Shield of Wisconsin and of the Wisconsin Plan; the chairman of the Society's Council on Medical Service and Public Relations; the chairman of the Veterans Medical Service Agency; and a member of the Council.

Problems common to the plans as well as problems of insurance unrelated to either of the Society-sponsored programs are referred to that committee for study and recommendation.

While there are many items pending on its agenda, there is one which the Council feels is important to report to the House at this time.

The Coordinating Committee recommended the creation of an Advisory Commission to the Society on the subject of prepaid plans. The committee has been given the "green light" by the Council. It is thought that the development of such an advisory body composed of interested and representative lay individuals will do much to aid the profession in the proper development and conduct of these plans.

On motion of Doctors Heidner–Christofferson, carried, the Council approved this report and referred it to the House of Delegates.

c. *Determination of Income under Prepaid Plans.* Two problems in regard to this subject were referred to the Coordinating Committee for study and recommendation. First, is the situation where a patient is covered by more than one plan or policy, indemnifying for the cost of professional services, at least one of which plans has a full payment provision. It was recommended by the committee and authorized by the Council that in such case the full payment provision not apply and that the attending physician not be limited to the fee schedule.

In other situations, it appears that only one member of the family may be entitled to benefits of the approved plans, with other members of the family not covered. In some cases, both the husband and wife have individual policies, obtained through different places of employment. The committee recommended, and the Council approved, that in all cases the combined income of the principal party insured, and eligible members of the family, should govern eligibility to the full payment provision of the plan.

On motion of Doctors Dessloch–Kasten, carried, this report was approved for reference to the House of Delegates.

d. *Remission of Dues for Members in Service.* The Council has re-established the policy of the Society in World War II, providing that those in active service, and not on a career basis, shall have dues waived while in service.

On motion of Doctors Hemmingsen–Eck, carried, this report was approved for reference to the House of Delegates.

9. Report on Rural Health Conference

Doctors Eck, Kasten, and Christofferson, and Mr. Thayer presented the Council with a report on the Rural Health Conference held at Green Lake in September. Opinions expressed indicated that a successful meeting was held, with approximately 275 people attending from organizations interested in rural health.

10. Checking Account for Payroll Checks

Secretary Crownhart reported that the Society's certified public accountant had recommended that it would be feasible to establish a separate checking account for the payroll of all employees of the Society, including its agencies. It was suggested that a resolution be approved designating the First National Bank of Madison as the depository for the payroll account.

On motion of Doctors McCarey–Christofferson, carried, this resolution was approved.

11. Candidates Meeting

Secretary Crownhart reported on the progress made in extending invitations to political candidates for governor, House of Representatives, and the United States Senate to address the members at a special meeting on Monday evening, October 2.

It was moved by Doctors Ekblad–Pierce that a transcript of this meeting be sent to every member. An amendment was offered by Doctors Dessloch–Kasten that the Interim Committee determine whether the statements made would be of sufficient interest to every member to permit the Society to incur the cost of printing the transcript in its entirety. Both the amendment and motion were carried.

12. Hospital Standardization

Secretary Crownhart stated that in a letter from Dr. George F. Lull, secretary of the American Medical Association, the Society was advised that the House of Delegates of the American Hospital Association, meeting in Atlantic City in September, adopted a resolution authorizing a hospital standardization program owned and operated by the hospital association. When it was first reported that the American College of Surgeons was withdrawing from hospital standardization, the American Medical Association Board of Trustees appointed a committee which met with college representatives on two different occasions. At both meetings the Amer-

ican Medical Association pressed for a postponement so that all concerned could study the problem. This feeling was passed on to the American Hospital Association. In addition to telegraphing the president of the American Hospital Association, the president of the American Medical Association and two members of its Board of Trustees—Elmer L. Henderson and Trustees E. J. McCormick and Gunnar Gundersen—met with representatives of the American Hospital Association in Atlantic City, the day the session opened. At that time the American Medical Association representatives reiterated the position of the American Medical Association: that the professional staffs of hospitals must not be placed under control of hospital administrators.

Dr. Gunnar Gundersen also explained discussions had by the American Medical Association with representatives of the Hospital Association and background material on the subject.

At this point, the Council recessed until 9:30 Sunday morning.

It was suggested that the following resolution be submitted by the Council to the House of Delegates with regard to the standardization of hospitals:

> WHEREAS one of the many problems in the training and education of a physician is the standardization of hospitals for the purpose of intern and resident opportunities, and
>
> WHEREAS this has been a long time project for the medical profession, through the American Medical Association and the American College of Surgeons, an activity bringing about a consistent evaluation of medical staff and patient facilities sufficient for the purpose, and
>
> WHEREAS it has been the recently declared intention of the American Hospital Association to enter into this field in view of the fact that the American College of Surgeons has expressed the intention of withdrawing, and
>
> WHEREAS the Board of Trustees and officers of the American Medical Association have expressed the willingness of the Association to assume as much of the program as has heretofore been carried on by the American College of Surgeons, and have expressed their belief that the standardization of hospitals for this particular purpose constitutes a professional and scientific evaluation which lay administrators and boards of trustees of hospitals are obviously unqualified to exercise by lack of scientific and professional training,
>
> *Therefore Be it Resolved* by this House of Delegates that it express to the American Medical Association its complete support of the program in this field,
>
> *Be it Further Resolved* that a copy of this resolution be sent to all state medical associations as well as to the president and secretary of each component county medical society of the State Medical Society.

On motion of Doctors Heidner–McCarey, carried, the resolution was approved for reference to the House of Delegates.

13. Cooperative Health Plans

Secretary Crownhart presented a review of the development of cooperative health care plans in the state. Dr. W. J. Houghton of Wisconsin Dells also reported on the movement in his area. He suggested that the Council authorize a committee to study the situation, to inform the members, and to make recommendations, so that members in the state are informed. It was noted that the Committee on Coordination of Health Care Plans already exists and might well consider this matter.

It was also noted that a Committee on Cooperatives had been created previously to make studies on the cooperative movement and that it might be well to have that committee meet with the Coordinating Committee in considering the matter. The consensus was that this be done.

14. American Medical Association Membership Obligatory on Members of the State Society

Doctor Gundersen, as a member of the Board of Trustees of the American Medical Association proposed that the Council consider passage of a resolution to provide that membership in the American Medical Association be obligatory on members of the State Society in an effort to strengthen the parent organization.

Following discussion, it was moved by Doctors Fox–Bell, carried, that the secretary be instructed to form a resolution to be presented to the House of Delegates to the effect that membership in the American Medical Association be obligatory upon members of the State Society.

15. Report of the Committee on Military Medical Service

Dr. F. L. Weston, chairman of the committee, presented a report on the progress of the committee, and on motion of Doctors Ekblad–Eck, carried, the report was approved for reference to the House of Delegates.

16. State Board of Health

Doctor Gavin, president of the State Board of Health, introduced members of the State Board who had been invited to meet with the Council at this session.

Doctor Neupert, state health officer, reviewed activities of the State Board of Health since it was made an official agency under the Statutes of Wisconsin in 1876. He explained that the State Board is made up of members appointed by the governor with the consent and approval of the Senate. Each of the seven members is appointed for a term of seven years in rotation. The secretary is appointed by the Board, not by the governor, and requires no confirmation by the Senate. He is immediately responsible to the Board which sets all policies and makes all decisions. Meetings are held each month as required by law. Rules and regulations are published as well as the laws pertaining to the Board. These laws are effective until challenged and tried in court or changed by the Board.

An Organization and Functions Chart was distributed. It was noted that the State Laboratory of Hygiene was established in 1903, the Bureau of Vital Statistics in 1905, handling birth certificates, death certificates, marriage licenses, and the like.

The Bureau of Nursing Education, started in 1911, was made a Board of Nurses outside of the State Board of Health in 1949. There are eight divisions for licensing of barbers, beauty parlors, plumbing, and hotels and restaurants and others.

In 1936 the Federal Social Security Act and its grants-in-aid program enabled the State Board of Health to set up needed divisions and augment activities as a result of the availability of federal funds.

For efficiency in office, the State Board of Health is divided into various sections for preventable diseases, environmental sanitation, general administration including the division of laboratories, statistical services, dental education, vital statistics, health education, hospital survey and construction, and licenses. There are also sections on local health administration and on maternal and child health.

Frequent staff conferences are held between the heads of the sections and the secretary.

The state is allocated into nine districts. Each district has a staff which handles local problems. County health departments, as well as city departments are being urged at present.

A bi-monthly bulletin is published by the Board to which members of the Medical Society have submitted articles.

Some years ago the Board made certain biologicals available on a cost basis, particularly diphtheria antitoxin, rabies vaccine, smallpox vaccine, and those biologicals which were not commonly well stocked and which had to have refrigeration. As a result of studies and recommendations made to the legislature, this policy was altered as follows: at present drugs and biologicals are furnished by the Board of Health for the field of anti-syphilitics. A limited fund is available to pay physicians for the treatment of venereal disease for which penicillin and other drugs are furnished. Treatment is rendered only to non-residents with an infectious disease when the physician cannot receive payment from them and for the treatment of indigent patients with an infectious venereal disease. Physicians provide reports as to those they treat and a follow-up is made.

The State Laboratory of Hygiene, under Dr. W. D. Stovall, manufactures silver nitrate for the prevention of ophthalmia neonatorum in the newborn. It also prepares tuberculin for skin tests.

Human immune globulin from blood that was donated during the war is provided through the Red Cross to the Board of Health which makes it available to some local boards. It is provided at no cost, for prevention of serious complications in measles, and the physician agrees not to charge for the material, although he may charge for its administration.

Doctor Stovall stated that the State Laboratory of Hygiene has rendered services to doctors, that they could not otherwise get, particularly in rural areas. Additional facilities are needed, and the legislature in the last legislative session provided $750,000 to be matched by the federal government in its hospital construction program, for the purpose of increasing the facilities. The appropriation plus the federal allotment totals $1,363,000. It is proposed that at the next session of the legislature additional funds will be asked to provide additional staff for the new Laboratory of Hygiene.

Mr. Crownhart reported that the secretary's office has a standing invitation to attend Board of Health meetings.

A non-official Public Health Council was organized in 1948 at the suggestion of the State Board of Health. The Council's prime objectives are confined at present to two major projects: (1) the encouragement of county public health councils, and (2) the encouragement of the development of the county health unit. One of the employees of the State Board, Miss Gertrude Clouse, was made available by the State Board of Health and was appointed as full-time executive secretary by the Wisconsin Public Health Council. Mr. Crownhart recommended that the Council give thought to expressing an opinion that every effort be made to make the Public Health Council a self-financed body, with organizations belonging to it paying dues on a per capita basis.

Doctor Neupert then outlined the suggestions of the Kellogg Foundation that through the State Health Department someone be provided by the Foundation to work with hospitals which do not now have organized diagnostic facilities in x-ray and laboratories, to group them together and set up laboratory departments and pathologists and roentgenologists on a group basis for the purpose of providing services not now available. The Foundation would provide the Board staff with a qualified person for a period of three years to help with this problem in hospitals that are interested in it.

Following discussion, on motion of Doctors McCarey–Kasten, carried, the chairman was authorized to appoint a committee of three for terms of short duration, to study the question of the State Board of Health supplying biologicals to physicians who were unable to obtain them in their home communities, and to study the proposal of the Kellogg Foundation to provide an individual to work with hospitals in organizing diagnostic facilities.

Doctor Arveson announced his appointments to this committee as Doctors Fox, Heidner, Tenney, and Houghton, who were asked to report at a future Council meeting.

17. Adjournment

The Council adjourned at 12:30 p.m.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson
Chairman of the Council

RECENT WISCONSIN LICENTIATES

At a meeting held in Milwaukee on July 11–13, the Wisconsin State Board of Medical Examiners licensed the following physicians in the practice of medicine after they had successfully passed an examination:

Name	*School of Graduation*	*Year*	*Address*
Albrecht, D. J.	Marquette	1949	2917 West Mitchell, Milwaukee
Allin, T. G., Jr.	Wisconsin	1949	1815 Summit, Madison
Axelrod, Sidney	Buffalo	1942	3373 North Hackett, Milwaukee
Baernstein, H. D.	Wisconsin	1949	Naval Air Station, Virginia Beach, Virginia
Bardenwerper, H. W.	Chicago	1949	1839 Wauwatosa, Milwaukee
Becker, R. J.	Marquette	1949	1809 East Marion, Shorewood
Bennett, J. E.	Northwestern	1950	Box 425, Burlington
Bishop, P. R.	Wisconsin	1949	Dodgeville
Boldon, E. I., Jr.	Wisconsin	1949	Christ Hospital, Cincinnati, Ohio
Brazos, J. C.	Illinois	1949	310½ North Third, Watertown
Caine, Donald	Temple	1949	1938 North Thirty-Eighth, Milwaukee
Cooney, R. T.	Boston	1948	De Forest
Cranston, R. W.	Wisconsin	1949	1137 Xerxes South, Minneapolis
Curry, J. C.	Marquette	1949	297 Fourth Street, Fond du Lac
Dall, G. A.	Marquette	1949	3069 North Thirty-Eighth, Milwaukee
Derse, J. J.	Marquette	1949	2343 North Maryland, Milwaukee
Dukerschein, F. N.	Wisconsin	1949	2017 Corscut Circle, Madison
Enneking, W. F.	Wisconsin	1949	1201 Ellis Street, Stevens Point
Erickson, L. W.	Minnesota	1950	Burlington
Fishbain, Harold	Wisconsin	1949	City Hospital, Springfield, Ohio
Fox, M. J.	Marquette	1949	2905 West Villard, Milwaukee
Gallaher, D. M.	Northwestern	1949	821 East Washington, Appleton
Glise, R. C.	Iowa	1949	Lutheran Hospital, La Crosse
Graf, A. E.	Tufts	1947	Racine
Groh, J. A.	Marquette	1949	521 North Center, Appleton
Gundersen, G. A.	Harvard	1948	Route 2, La Crosse
Hammersley, D. W.	Wisconsin	1948	2119 Potomac Drive, Topeka, Kansas
Hanson, S. M.	Marquette	1948	309 East Main, Sparta
Hanson, Teresa S. (F)	Marquette	1948	309 East Main Street, Sparta
Haskins, P. S.	Wisconsin	1949	2048 River Street, Niagara
Holvey, S. M.	Wisconsin	1949	2640 Burnet, Cincinnati, Ohio
Jake, R. J.	Vermont	1949	Columbia Hospital, Milwaukee
Johnson, J. R.	Wisconsin	1946	1433 Golden Street, Ann Arbor, Michigan
Johnson, R. O.	Wisconsin	1948	515 Cochrane, Eau Claire
Jones, L. E.	Marquette	1949	1401 Grand Avenue, Racine
Kasper, R. E.	Marquette	1949	320 Eighth Avenue Southeast, Aberdeen, South Dakota
Klein, R. J.	Marquette	1949	1135 East Lexington, Milwaukee
Korducki, S. A.	Marquette	1949	2719 South Fifteenth Street, Milwaukee
Kozokoff, N. J.	Loyola	1949	8700 West Wisconsin, Milwaukee
Kretchmar, J. S.	Marquette	1949	2821 East Menlo, Shorewood
Krumenacher, F. P.	Wisconsin	1949	1655 North Humboldt, Milwaukee
Larkin, C. B.	Wisconsin	1949	641 Knickerbocker, Madison
Larsen, L. L.	Jefferson	1949	2668 South Twenty-Eighth Street, Milwaukee
Lee, S. R.	Wisconsin	1949	Verona
Lepley, Derward, Jr.	Marquette	1949	454 North Twenty-Eighth Street, Milwaukee
Lifson, B. I.	Wisconsin	1949	4459 North Oakland, Milwaukee
Litzow, T. J.	Marquette	1949	216 Wabash Avenue, Waukesha
Mann, G. A.	Marquette	1949	115 Twelfth Avenue East, Menomonie
McGabe, L. B.	St. Louis	1949	136 Sheboygan, Fond du Lac
Meves, T. F.	Indiana	1948	3922A North Forty-Second, Milwaukee
Meyer, C. F.	Iowa	1949	Independence
Natvig, Paul	Marquette	1949	Prairie Farm
Noll, D. J.	Wisconsin	1949	565 Indian Drive, Midwest City, Oklahoma
Oakley, Dorothy H. (F)	Wisconsin	1949	1004 East Dayton, Madison
Odland, P. K.	Temple	1946	1862 North Thirty-Ninth, Milwaukee
Osicka, S. R.	Marquette	1949	Amherst
Pedersen, Elaine K. (F)	Wisconsin	1949	2200 West Kilbourn, Milwaukee
Pilliod, J. V.	Loyola	1949	2039 West Wisconsin, Milwaukee
Plank, L. E.	Marquette	1949	3532 North Fourteenth Street, Milwaukee
Price, D. J.	Marquette	1949	828 Montana South, Milwaukee
Quinn, R. H.	Marquette	1949	City Hospital, New York 17, New York
Rademacher, Hansi	Wisconsin	1949	St. Joseph's Hospital, Marshfield
Ragaz, F. J. B.	Wisconsin	1949	1811 Underwood, Wauwatosa
Roberts, W. J.	Wayne	1949	De Forest
Rosenbaum, D. M. K. (F)	Wisconsin	1949	530 West Johnson, Madison
Royce, M. E.	Wisconsin	1949	Mayville

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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Name	*School of Graduation*	*Year*	*Address*
Schalmo, E. H., Jr.	Wisconsin	1949	1728 Martha Washington Drive, Wauwatosa
Schelble, J. A.	Marquette	1949	4244 North Wilson, Milwaukee
Schmidt, C. W.	Wisconsin	1949	Gresham
Schneider, C. J.	Tulane	1948	8844 Watertown Plank Road, Milwaukee
Schulz, E. G.	Western Reserve	1949	Milwaukee County Hospital, Milwaukee
Schuyler, Jean M. (F)	Wisconsin	1949	Fish Creek
Scovill, Janet R. (F)	Columbia	1943	602 Fifteenth Avenue, Monroe
Simmons, V. P.	Chicago	1949	7930 Gridley Avenue, Wauwatosa
Smigielski, K. M.	Marquette	1949	2666 South Fifteenth Place, Milwaukee
Strawitz, J. G.	Wisconsin	1949	3364 North Downer, Milwaukee
Sullivan, E. J.	Marquette	1949	1323 Randall Court, Madison
TenPas, R. H.	Wisconsin	1949	Route 3, Sheboygan Falls
Thomas, R. H.	Wisconsin	1949	St. Joseph's Hospital, Phoenix, Arizona
Thomson, G. H.	Western Ontario	1949	1203 Middle Street, Beloit
Tormey, A. R., Jr.	Wisconsin	1949	1228 Sherman Avenue, Madison
Vinograd, S. P.	Wisconsin	1946	St. Mary's Hospital, Madison
Walter, K. E.	St. Louis	1949	1703 Rust Street, Eau Claire
Way, R. W.	Wisconsin	1949	Route 4, Madison
Ziehl, F. L.	Marquette	1946	1604 South Seventy-Second, Milwaukee
Zurheide, H. J.	Wisconsin	1949	8041 Warren Avenue, Wauwatosa

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners following examination at Milwaukee on July 11–13.

Name	*School of Graduation*	*Year*	*Address*
Alexander, H. A.	Minnesota	1930	4711 Thirtieth Avenue South, Minneapolis
Barnes, M. E., Jr.	Iowa	1941	22 North Hancock Street, Madison
Buffmire, D. K.	Northwestern	1947	1529 Damon Court, Rochester, Minn.
Canfield, Albert	Minnesota	1943	2 West Gorham, Madison
Carney, J. F.	Northwestern	1943	7 West Madison, Chicago
Chase, Jules	New York	1940	3278 North Shepard Avenue, Milwaukee
Clough, John	Washington	1944	Madison General Hospital, Madison
Cortner, J. W.	Western Reserve	1947	2228 Kendall Avenue, Madison
Couter, W. T.	Michigan	1943	4621 Beacon Street, Chicago
Ekwall, M. L.	Nebraska	1946	Box H, Winnebago
Evensen, N. A.	Colorado	1944	Mendota State Hospital, Madison
Fogelberg, Alma (F)	Northwestern	1948	Jackson Clinic, Madison
Foultz, W. S.	Illinois	1947	16 South Henry Street, Madison
*Hamilton, Mary F. (F)	Arkansas	1938	Winnebago State Hospital, Winnebago
Harter, Leo	Pittsburgh	1944	16 South Henry, Madison
Hayes, D. M.	George Washington	1940	St. Luke's Hospital, Milwaukee
Henken, W. F.	Northwestern	1947	Milwaukee Children's Hospital, Milwaukee
Hopkins, G. J.	George Washington	1946	Hudson
Hotz, L. O.	Northwestern	1947	5117 Lee Street, Skokie, Illinois
Johnston, W. A.	Michigan	1919	1200 Main, Dubuque, Iowa
Jones, E. T.	Minnesota	1942	1849 Sixth Street, Beloit
Kamholz, J. H.	Pennsylvania	1942	5346 Chew Avenue, Philadelphia
Kleaveland, I. J.	Western Reserve	1947	Wisconsin General Hospital, Madison
Knight, R. G.	Western Reserve	1948	136 Second Street, Reedsburg
Knudson, R. A.	Louisville	1945	Forest Lake, Minnesota
Kuljis, D. A.	Marquette	1942	701 South Globe Avenue, Freeport, Ill
Lukasek, E. O.	Chicago	1946	946 South Home Avenue, Oak Park, Ill.
Lyons, R. P.	Loyola	1943	16 South Henry Street, Madison
McCain, D. L.	Minnesota	1937	662 Lowry Building, St. Paul, Minn.
Meyer, J. M.	Marquette	1943	2862 North Ninety-First Street, Milwaukee
Miller, R. J., Jr.	Northwestern	1947	1300 University Avenue, Madison
Mount, H. F.	Oklahoma	1946	Marshfield Clinic, Marshfield
Nafziger, E. G.	Hahnemann	1947	Fairview, Michigan
Noble, J. H.	Illinois	1947	Box 426, Graceville, Minn.
Petersen, E. S.	Harvard	1945	1322 Astor Street, Chicago
Reimers, L. H.	Northwestern	1932	1528 Cullom, Chicago
Rivera, R. R.	Northwestern	1946	3628 East Armour Avenue, Cudahy
Schlereth, J. R.	Loyola	1945	1115 Oakwood Avenue, Napoleon, Ohio
Stiles, F. C.	Colorado	1946	Milwaukee Children's Hospital, Milwaukee
Tompsett, A. C.	Michigan	1943	2021 North Fifth Street, Sheboygan
Van Lier, P. C.	Amsterdam (Holland)	1932	Sioux Falls Clinic, Sioux Falls, S. D.
**Wichelman, D. F.	Minnesota	1948	Milwaukee County Hospital, Milwaukee

* Examination given at Madison on January 12.

** Examination given at Milwaukee on July 12.

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**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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Society Proceedings

Brown—Kewaunee—Door

R. H. QUADE

Meeting at the Chatterbox in De Pere on October 12, members of the Brown–Kewaunee–Door County Medical Society heard a talk by *Dr. R. H. Quade*, Neenah neurologist. Doctor Quade discussed "Head Injuries." *Dr. A. J. McCarey*, Green Bay, Councilor for the Sixth District, and the delegates reported on the proceedings of the House of Delegates of the State Medical Society in October. A routine business meeting was held on September 14 at the Leathem Smith Lodge, Sturgeon Bay.

Calumet

A dinner meeting of the Calumet County Medical Society and its Auxiliary was held at the Old Mill near Chilton on October 12. A report of the House of Delegates meeting of the State Medical Society in Milwaukee was presented by *Dr. Everett Humke* of Chilton.

Chippewa

Meeting at Krause's Cafeteria at Chippewa Falls on October 10, members of the Chippewa County Medical Society heard talks by two staff members of the Mayo Clinic, Rochester, Minn. Dr. R. B. Wilson discussed "Estrogens and Their Use in Obstetrics and Gynecology," and Dr. W. G. Sauer spoke on "Diverticulosis and Diverticulitis." At the election of officers which followed, *Dr. C. T. Clauson* of Bloomer was named president; *Dr. W. F. Janc*, Chippewa Falls, vice-president; *Dr. T. D. Foster*, Cornell, secretary; *Dr. John Sazama*, Chippewa Falls, delegate; and *Dr. S. E. Williams*, Chippewa Falls, alternate delegate.

Crawford

Members of the Crawford County Medical Society held a dinner meeting at the San Hotel in Prairie du Chien on October 18.

The group met at Kaber's Nite Club in Prairie du Chien on September 27.

Dodge

The "Effects of Atomic Warfare and Radiation Exposure" was the subject discussed at the meeting of the Dodge County Medical Society at St. Joseph's Hospital, Beaver Dam, on September 28. *Dr. Howard Bayley*, Beaver Dam, was the principal speaker. Films of the United States Navy and the pathologic changes resulting from atomic exposure were also shown.

Eau Claire—Dunn—Pepin

Dr. Herman W. Wirka, professor of orthopedics at the University of Wisconsin Medical School, was the guest speaker at a meeting of the Eau Claire–Dunn–Pepin County Medical Society on October 30 at the Hotel Eau Claire. Doctor Wirka discussed "The Knee." A business meeting was held by the members at the Hotel Eau Claire on August 28.

Fond du Lac

Dr. D. J. Twohig, Jr., Fond du Lac, was named president of the Fond du Lac County Medical Society at its annual business meeting on September 28 at Schreiner's Restaurant in Fond du Lac. Serving with Doctor Twohig will be *Drs. R. W. Steube*, vice-president; *F. J. Cerny*, secretary; *R. W. Schroeder*, treasurer; and *Orvil O'Neal*, censor. All are from Fond du Lac except Doctor O'Neal, who practices in Ripon.

Jefferson

The Jefferson County Medical Society held a pre-State Medical convention meeting at the Blackhawk in Fort Atkinson on September 21. *Dr. C. J. Garding*, Jefferson, delegate, discussed the business to come before the State meeting, and *Dr. G. E. Eck*, Lake Mills, Councilor from the First District, presented the motions to be voted on by the group.

Kenosha

The president of the Wisconsin Heart Association, *Dr. Francis F. Rosenbaum*, Milwaukee, was the guest speaker at a meeting of the Kenosha County Medical Society at the Elks Club in Kenosha on October 5. He discussed "Cardiac Emergencies."

Marinette—Florence

Members of the Marinette–Florence County Medical Society gathered in the Doctor's Room of St. Joseph's Hospital on October 18 to hear a talk by *Dr. Elwood W. Mason* of Milwaukee. Doctor Mason, who is an assistant clinical professor of medicine at Marquette University School of Medicine, discussed intestinal disorders.

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Outagamie

Dr. Joseph Shaiken, Milwaukee, discussed "Progress in Diagnosis and Management of Gastrointestinal Diseases" at the October meeting of the Outagamie County Medical Society. The meeting was held at the Riverview Sanatorium in Appleton on October 19. Doctor Shaiken is an assistant clinical professor of medicine at Marquette University School of Medicine.

Racine

Members of the Fifty Year Club of the Racine County Medical Society were honored by that organization at a dinner meeting on October 19 at the Racine Country Club. Honored guests were *Drs. L. E. Fazen, Sr.*, Racine; *R. W. McCracken*, Union Grove; and *Frederick Peehn* of Sturtevant. *Dr. W. C. Hanson*, of Racine, was unable to be present. Three movies on medical surgery were shown, and a post-convention business meeting followed.

Trempealeau—Jackson—Buffalo

Dr. Harold M. Coon, superintendent of the State of Wisconsin General Hospital, Madison, spoke before a meeting of the Trempealeau–Jackson–Buffalo County Medical Society at the Clubhouse in Arcadia on October 19. He discussed the administrative activities of Wisconsin General Hospital and also talked on the draft problem affecting the interns and residents. *Dr. E. R. Schmidt*, professor of surgery at the University of Wisconsin Medical School, was also a guest speaker, discussing "Newer Advances in Surgery."

Washington—Ozaukee

Dr. O. J. Hurth of Cedarburg was honored at a meeting of the Washington–Ozaukee County Medical Society and its Auxiliary at the Cedars on September 28, on the occasion of his fiftieth year in the practice of medicine. *Dr. J. W. Truitt*, Milwaukee, president of the State Medical Society, was the principal speaker. Other guests included *Drs. G. A. Hipke, William Ackermann, L. W. Hipke, J. V. Bolger*, and *M. M. Hipke*, all of Milwaukee.

Doctor Hurth, a graduate of Milwaukee Medical College, now Marquette University School of Medicine, interned at Trinity Hospital. He located in Cedarburg shortly afterward and has practiced there continuously for the fifty year period.

Winnebago

Dr. Philip Thorek, Chicago, addressed the members of the Winnebago County Medical Society at the Valley Inn, Neenah, on October 5. His subject was "Jaundice."

Wisconsin Society of Pathologists

Dr. W. A. D. Anderson, Milwaukee, was named president of the Wisconsin Society of Pathologists at a meeting held in conjunction with the Annual Meeting of the State Medical Society in Milwaukee on October 4. *Dr. Walter H. Jaeschke*, Madison, was elected vice-president; and *Dr. Robert S. Haukohl*, Milwaukee, secretary-treasurer. *Drs. D. Murray Angevine*, Madison; *John B. Miale*, Marshfield; and *L. J. Van Hecke*, Milwaukee, will constitute the Board of Censors.

Wisconsin State Obstetrical and Gynecological Society

The semi-annual meeting of the Wisconsin State Obstetrical and Gynecological Society was held in Shawano on October 13, with *Dr. A. A. Cantwell* of that city as host. The scientific sessions were held in the Utility Building, with a luncheon served at the Bilmay Hotel. Dr. John W. Huffman of Wesley Hospital, Chicago, was the guest speaker, and eight members of the Society presented scientific papers.

American Academy of General Practitioners Fond du Lac Chapter

Members of the Fond du Lac Chapter of the American Academy of General Practitioners heard a talk by *Dr. W. S. Middleton*, Madison, at a meeting on October 12 at the Hotel Retlaw in Fond du Lac. Doctor Middleton, dean of the University of Wisconsin Medical School, spoke on "Therapy of Blood Diseases Revised to Date."

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News Items and Personals

Pepin Observes "Doctor Belitz Day"

Grateful citizens of Pepin on September 21 paid tribute to their physician—*Dr. Alfred Belitz*—for thirty-two years of medical service to that community. The doctor has been in medical practice for a total of fifty-five years. Doctor Belitz Day was sponsored by the Commercial Club of Pepin, with churches in the community cooperating. A tea was held in the afternoon, and the celebration was climaxed with a dinner, at which a plaque was presented to the doctor.

A member of the Fifty Year Club of the State Medical Society, Doctor Belitz was born at Kiel. He received his M. D. degree from the Chicago College of Physicians and Surgeons, now incorporated into the University of Illinois College of Medicine, in 1895. Because of ill health, he left a practice in Chicago to go west in 1898, practicing first at Gunnison, Utah, and later at Seattle, Wash., and San Jose, Calif. Subsequently he moved to Wisconsin, practicing at Milwaukee, where he was also on the staff of the Wisconsin College of Physicians and Surgeons. Later he returned to Utah for a short period before locating in Pepin. A life member of the State Medical Society, he has served as village health officer of Pepin.

Marshfield Pathologist Speaks at Anniversary Celebration

J. H. MIALE

Dr. John B. Miale, Marshfield pathologist, presented an address at the twenty-fifth anniversary celebration of the University of Rochester School of Medicine, Rochester, N. Y., October 12–14. The celebration was in honor of Dr. George H. Whipple, dean of the medical school, and Nobel prize winner for his work in anemias, and speakers were his former students. Doctor Miale, who studied in his department for two years, spoke on "The Relationship of Coagulase-Globulin to Prothrombin as Studied by the Staphylocoagulase Reaction."

Dr. H. J. Kenney Elected to Fellowship in Surgical Group

Dr. Howard J. Kenney, Delavan physician, was recently elected to the rank of certified fellow in the International College of Surgeons and was admitted as such at the convention of the organization in Cleveland, Ohio, October 30–November 3. Doctor Kenney is a graduate of Marquette University School of Medicine.

Dr. D. H. Hinke Named City Health Officer

Dr. Dayton H. Hinke, Richland Center, was recently named city health officer, to fill the vacancy created by the death of *Dr. Gideon Benson* of that community. Doctor Hinke, a graduate of the University of Pennsylvania School of Medicine, served in the Army Medical Corps and was associated with the department of surgery at Mayo Clinic before locating in Richland Center in 1948.

Burlington Hospital Elects Staff Officers

Dr. H. W. Granzeau, Burlington, was elected president of the medical staff of the Burlington Memorial Hospital at a recent meeting. Other physicians named to office were *Drs. J. D. VanLiere*, Burlington, vice-president; and *Laird McNeel*, Genoa City, secretary-treasurer.

Indian Physician Addresses Woman's Club

Dr. Lillie Rosa Minoka-Hill, physician at Oneida for many years, spoke at a luncheon meeting of the Plymouth Woman's Club at the Hotel Mitchell, Plymouth, on September 27. The doctor told of her medical practice on the Oneida reservation near Green Bay, for which she was given the title of "most outstanding Indian of 1947" by the Indian Council Fire, an organization affiliated with the Illinois Federation of Women's Clubs. In 1949 she was honored by the American Medical Association and the Woman's Medical College of Philadelphia as a fifty year graduate of that institution.

Manitowoc Doctor Speaks to Junior Service League

Dr. Keith Keane, a member of the staff of the Manitowoc Child Guidance Center, spoke before the Junior Service League of Manitowoc on October 5. He discussed the work of the guidance center and emphasized the importance of recognizing symptoms of mental disease in children, before they become a fixed part of the individual personality.

Brodhead Physician Addresses Lay Groups

Dr. M. W. Stuessy, Brodhead, addressed the convention of the Wisconsin Association of Cooperatives in Sheboygan on October 20. His subject was the different types of medical services in the doctor's office and in the hospital. The doctor spoke on "Socialized Medicine" at a meeting of the Woman's Society of Christian Service at Albany on October 17.

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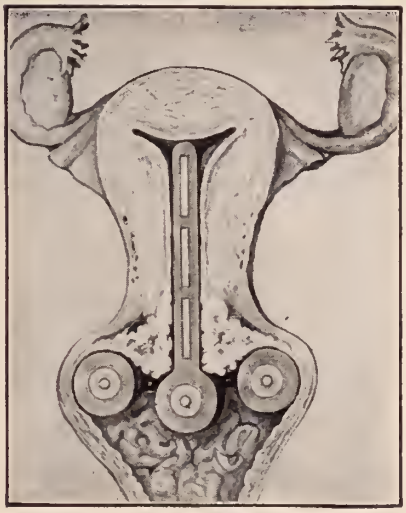

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Shawano Doctor Addresses Rotarians

Dr. Roger C. Cantwell, Shawano, discussed heart disease before a meeting of the Rotary Club of that city on October 9. He stated that one out of every twenty persons has some kind of heart disease and pointed out that some form of heart condition is responsible for one out of three deaths. He also discussed the work of the American Heart Association in carrying on research to reduce the fatalities from heart conditions.

Dr. H. H. Kleinpell Honored For Fifty Years' Service

Friends and relatives of *Dr. H. H. Kleinpell*, Prairie du Chien, honored the doctor for his fifty years of medical service at a dinner and reception on October 8 at Elkader, Iowa. The doctor was admitted to membership in the Fifty Year Club of the State Medical Society at the Annual Dinner of the Society in Milwaukee, October 3. A graduate of Rush Medical College, Chicago, Doctor Kleinpell practiced in Chicago until 1933, when he moved to Prairie du Chien.

Neenah Hospital Staff Hears Dr. George Hildebrand

At a meeting of the staff of Theda Clark Memorial Hospital, Neenah, on September 29, *Dr. George Hildebrand*, Menasha, presented a paper entitled "A Count of Hospital Cases."

Boscobel Organizations Hear Talks on Heart Disease

Two groups of Boscobel citizens were given talks on heart disease by *Dr. George R. Barry*, Monroe physician, during the afternoon and evening of October 10. Parents and teachers were told of the dangers of rheumatic fever, and they were advised to check with the family doctor whenever symptoms of the disease appear. Members of the Kiwanis Club were warned that evening that they should ease up on work after the age of 40. Doctor Barry, a member of the staff of the Monroe Clinic, is a member of the board of directors of the Wisconsin Heart Association.

Neenah Physician Councilor to Radiology Society

According to a recent issue of the monthly news letter of the American College of Radiology, *Dr. S. R. Beatty*, Neenah radiologist, is serving as the Wisconsin councilor for the College. Doctor Beatty, who is on the staffs of Mercy Hospital, Oshkosh, and Theda Clark Memorial Hospital, Neenah, also maintains a private practice in Neenah.

Dr. H. A. Weisse Enters United States Navy

Dr. Harris A. Weisse, former Plymouth physician, was recently recalled to active duty in the United States Navy. He left for the West Coast on October 14.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Oregon Physician Begins Training in Atomic Energy

Dr. B. H. Roisum, Oregon physician, left this month for Rochester, N. Y., to begin a two year study of medical problems of atomic energy, under a fellowship awarded by the Atomic Energy Commission. The doctor was one of four physicians selected for the study. He will study for one year at the University of Rochester Medical School and then will be assigned to one of the atomic energy plants for a year's on-the-job training. Doctor Roisum, a graduate of the University of Wisconsin Medical School, has practiced in Oregon since May 1948.

Dr. Mabel G. Masten on Board of New Publication

A member of the Editorial Board of the new publication, *Neurology*, is *Dr. Mabel G. Masten*, professor of neuropsychiatry at the University of Wisconsin Medical School. The first issue of the magazine, which is the official publication of the American Academy of Neurology, will appear in January 1951.

Roentgen Ray Society Honors Dr. E. A. Pohle

Dr. E. A. Pohle, professor of radiology at the University of Wisconsin Medical School, attended the semicentennial meeting of the American Roent-

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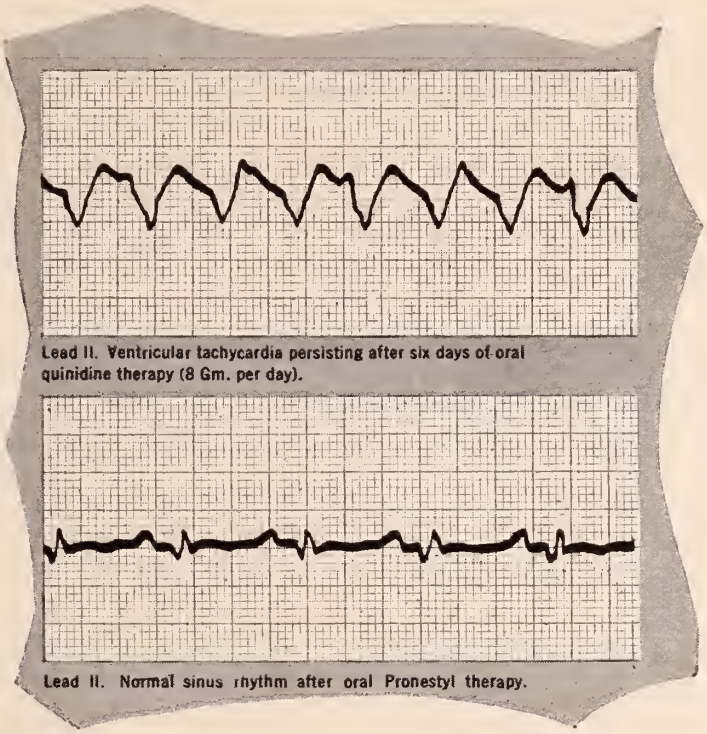

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Phones Answered Day and Night

gen Ray Society in St. Louis, September 25–29. He delivered a lecture as part of the refresher course program, entitled "X-Rays and Radium in the Treatment of Hemangiomas."

The doctor was also notified recently that the Detroit Roentgen Ray and Radium Society at its last meeting unanimously elected him an honorary member "in recognition of his outstanding contribution to medicine and the advancement of the science of radiology."

Dr. C. A. Harper Writes Book on Citizenship

Dr. Cornelius A. Harper, former state health officer, is the author of a booklet entitled "Many Reasons Why Every Voter Seriously Concerned in His or Her Future Freedom and Economic Security Should Vote," which is recently off the press. The doctor recognized the need for such a publication during his forty-six years of public office, when he discovered that such information was difficult for citizens to get in condensed form. Doctor Harper who is 87 years old, was state health officer for thirty-nine years.

Jackson Clinic Members Present Paper at Convocation

A paper entitled "Surgical Excision of Giant Panniculus Adiposus" was presented by *Dr. James A. Jackson*, Madison at the fifteenth annual assembly of the International College of Surgeons in Cleveland, Ohio, October 31–November 3. The article was written in cooperation with *Dr. John R. Steeper*. Both physicians are members of the staff of Jackson Clinic in Madison. At the meeting of the College, *Dr. Arnold S. Jackson*, also of the Jackson Clinic staff, was elected secretary.

SOCIETY PROCEEDINGS

Dane

Dr. C. G. Reznichek, Madison, was elected president of the Dane County Medical Society when the group met at the Madison Club in Madison on October 10. *Dr. J. K. Curtis* was named vice-president; *Dr. George Ewell*, president-elect; *Dr. George C. Hank*, secretary; *Drs. Ovid O. Meyer* and *J. A. Hurlbut*, delegates; and *Drs. J. A. Grab* and *L. E. Holmgren*, alternate delegates. All officers are from Madison, with the exception of Doctor Grab, who practices in Sun Prairie. A paper on "The Increased Significance of the Spleen" was presented by *Dr. John S. Hirschboeck*, dean of Marquette University School of Medicine and discussed by Doctor Meyer and *Dr. W. S. Middleton*, dean of the University of Wisconsin Medical School.

Rock

Dr. M. M. Baumgartner, Janesville, discussed the "Total Body X-Ray Radiation" at a dinner meeting of the Rock County Medical Society at the Hotel

Hilton, Beloit, on October 24. Colored slides illustrating the effects of atomic radiation on animals were used to illustrate the presentation.

At the annual election of officers, *Dr. H. W. Kishpaugh*, Beloit, was named president; *Dr. M. M. Baumgartner*, Janesville, vice-president; *Dr. George Peterson*, Beloit, secretary-treasurer; *Dr. Everett Reinardy*, Janesville, delegate; and *Dr. Richard A. Thayer*, Beloit, alternate delegate.

TWELFTH DISTRICT NEWS

Marquette University Announces Additions to Medical Staff

Dr. William W. Engstrom, who has been associated with the Yale University School of Medicine since 1946, was one of three assistant professors named this fall to the staff of Marquette University School of Medicine, Milwaukee. A specialist in glandular disorders, he is the first endocrinologist in Milwaukee.

Others appointed were *Dr. John E. Steinhaus*, department of pharmacology, who recently completed requirements for the degree of doctor of philosophy at the University of Wisconsin, and Dr. B. Wesley Catlin, former associate in research at Carnegie Institute, Long Island, N. Y.

Added to the faculty as an assistant clinical professor of medicine is *Dr. Michael W. Shutkin*, attending physician at Mount Sinai Hospital, Milwaukee.

Four Milwaukee physicians have joined the Marquette staff as clinical instructors. They are *Drs. Paul S. Pierson, Lloyd F. Jenk*, Walton D. Thomas, and *E. Franklin Carl*. Two Marquette medical faculty members were recently promoted to the rank of full clinical professors. They are *Drs. Edward R. Krumbiegel*, Milwaukee city health commissioner, Marquette department of public health, and *Gerhard D. Straus*, department of otolaryngology.

Full professorships were also awarded to Drs. Clement A. Fox, anatomy, and Michael Laskowski, biochemistry.

West Allis Physician is New Health Officer

Dr. John A. Van Susteren, West Allis, was appointed district 4 health officer, with headquarters at Sparta, by the State Board of Health at its meeting in Milwaukee, October 1. Doctor Van Susteren, a graduate of Marquette University School of Medicine, recently completed three years of service with the Army as post surgeon and assistant regimental surgeon in Japan. From March 1946 to July 1947 he was on a rotating internship at Madison General Hospital, Madison.

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Milwaukee Physicians Enter Military Service

Five Milwaukee physicians have recently notified the State Medical Society of their entrance into military service: *Dr. Robert H. Cassidy* on September 1 reported for duty with the United States Navy. He is stationed in the orthopedic department of the United States Naval Hospital at Oakland, Calif. *Dr. D. W. Calvy* also entered military service on September 1, and *Dr. John F. Wyman* entered the United States Navy in September.

Dr. Hanno H. Mayer, formerly in the practice of internal medicine in Milwaukee, is now on duty with the United States Navy.

Dr. J. W. Frye is in the Army Medical Corps, with the rank of captain.

Dr. L. R. Weinshel Elected to Surgical College

L. R. WEINSHEL

Dr. Leo R. Weinshel, Milwaukee, was recently notified of his election to fellowship in the American College of Surgeons in the field of general surgery. The new fellows were admitted at a convocation held on October 27. Doctor Weinshel, a graduate of Marquette University School of Medicine, served in the Army Medical Corps from 1941 to 1946, when he was discharged with the rank of lieutenant colonel.

Dr. M. G. Peterman Addresses Medical Groups

Dr. M. G. Peterman, Milwaukee pediatrician, on October 11 addressed the Wells County Medical Society in Fort Wayne, Ind., on "Febrile Convulsions." On October 26, in a talk before the Northwestern District Medical Society in Minot, N. D., he spoke on the same subject, and on October 28 he presented a paper entitled "The Treatment of Epilepsy in Children" at the Dakota Pediatric Society in Minot. The same title was given to a presentation which the doctor made at the Peoria (Ill.) Medical Society at its annual meeting on September 19. On October 5, he was the guest speaker at the fall meeting of the Northwest Pediatric Society in Bayport, Minn., where he discussed "Febrile Convulsions."

Milwaukee County Medical Examiner Resigns From Position

Dr. Edward L. Tharinger, Milwaukee County medical examiner since the position was created in 1944, has resigned from that position, effective December 31. The doctor, a graduate of Marquette University School of Medicine, has been a Milwaukee pathologist since 1915. He will continue his work with *Drs. L. J. Van Hecke* and *L. J. Kreissl, Jr.*, in their clinical pathology laboratory.

Urologists Meet in Milwaukee

The North Central Section of the American Urological Association met at the Hotel Schroeder, Milwaukee, October 12–14. The gathering was the twenty-fourth annual meeting of the section, which includes urologists from ten states and Manitoba, Canada. A high light of the program was a talk by Dr. W. J. Kolff, Cleveland, Ohio, inventor of the artificial kidney. His address was entitled "Artificial Kidneys and Their Possibilities." The Kolff type of artificial kidney was also among the scientific exhibits; it was sponsored by the Allis Chalmers Manufacturing Company, builder of two artificial kidneys for Milwaukee hospitals.

Dr. Walter M. Kearns, Milwaukee, was also among the exhibitors, displaying his recently developed method of protecting the kidneys when the bladder is removed because of cancer.

Dr. W. H. Drischler Named Student Health Physician

Dr. William H. Drischler, Milwaukee, was recently appointed part time physician for the new department of student health at the University of Wisconsin in Milwaukee. Formerly a captain in the Army Medical Corps, Doctor Drischler served as resident physician at the Veterans Administration Hospital, Wood, from 1946 to 1949.

Dr. F. E. Foerster Speaks to Homemakers

Guest speaker at the Cudahy Homemakers Club on October 19 was *Dr. Frederick E. Foerster*, Milwaukee, who discussed recent advances in the treatment of cardiac ailments. The doctor, a member of the staff of Marquette University School of Medicine, discussed medical and surgical treatment of heart disease, illustrating his lecture with a movie, "Heart of the Home."

Milwaukee Doctor Speaks to Dietetic Association

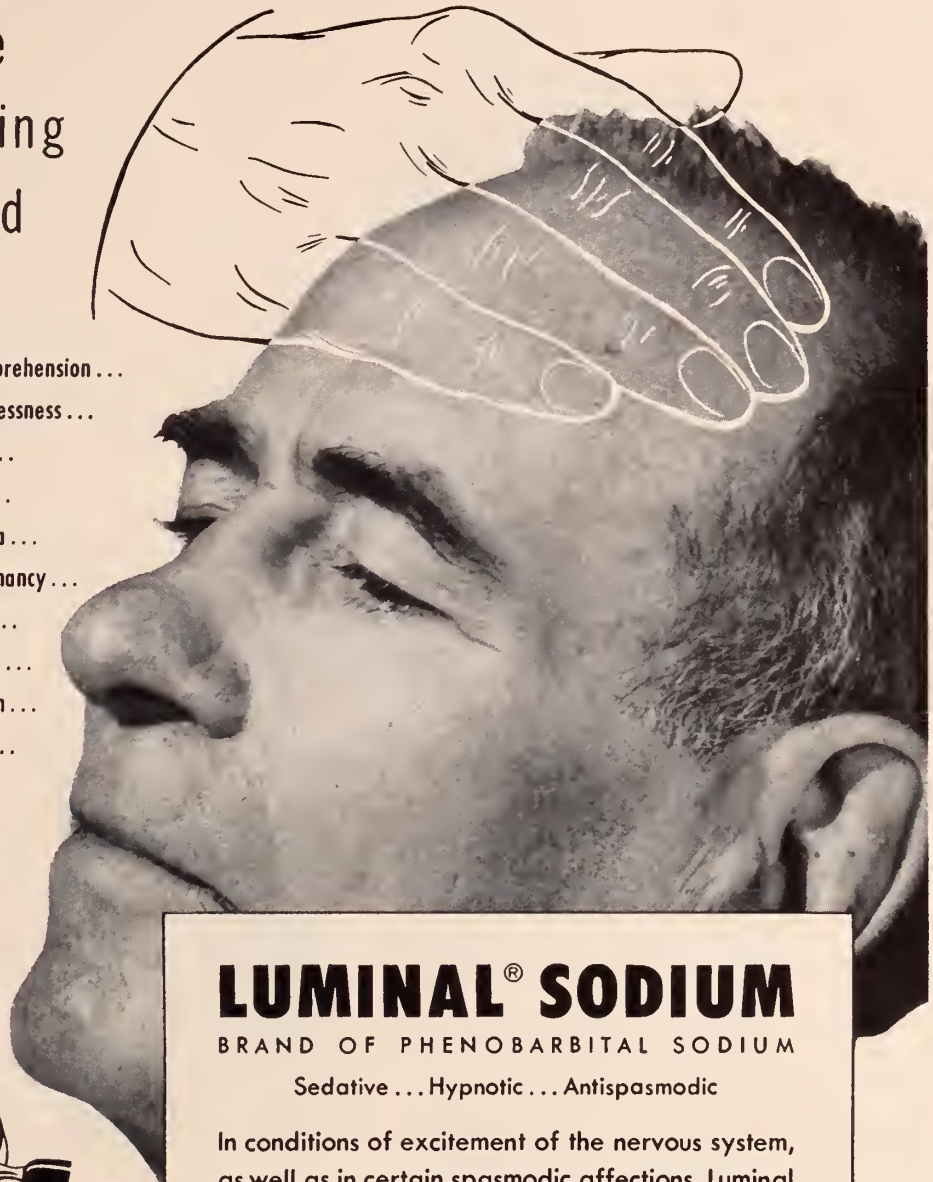
Dr. Daniel G. Santer, a member of the staff of the Milwaukee County General Hospital, spoke at a meeting of the Milwaukee Dietetic Association at the hospital on October 4. He discussed the artificial kidney.

SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

"Lesions of the Lumbosacral Spine" was the title of a presentation at the meeting of the Milwaukee Academy of Medicine at the University Club of Milwaukee on October 17. Dr. Paul C. Williams, associate professor of orthopedic surgery at South-

the quieting hand



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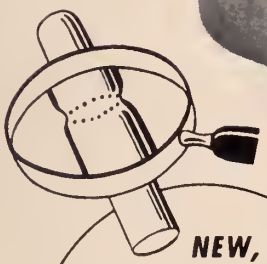

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western Medical School of the University of Texas, was the guest speaker.

Milwaukee Neuro-Psychiatric Society

The Winnebago State Hospital at Winnebago was the meeting place of the Milwaukee Neuro-Psychiatric Society on October 18. Following a tour of the hospital, a social hour and dinner were held at the home of *Dr. Byron J. Hughes*, superintendent of the hospital.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society met jointly with the Section on Ophthalmology and Otolaryngology of the State Medical Society on October 4 in the East Room of the Hotel Schroeder. Following a luncheon, papers were preesnted by Dr. William Hughes, professor of ophthalmology and Dr. Francis Lederer, professor of otolarygology at the University of Illinois College of Medicine.

SOCIETY RECORDS

New Members

C. K. Kline, 316 East Silver Spring Drive, Milwaukee.

W. D. Stovall, Jr., Brodhead.

J. C. Herweg, Monroe Clinic, Monroe.

W. V. Luetke, 1331 Drake Street, Madison.

J. K. Quinlivan, 1300 University Avenue, Madison.

F. F. Davis, 224 West Washington Avenue, Madison.

C. W. Aldridge, Jr., 118 East College Avenue, Appleton.

Changes of Address

R. R. Jacks, Elroy, to Menard, Illinois.

L. A. Dick, Marshfield, to 428 Stuart Avenue, Kalamazoo, Michigan.

H. F. A. Colfer, Westfield, New Jersey, to 9 Kempshall Terrace, Fanwood, New Jersey.

J. E. Steinhaus, Madison, to 2862 North 44th Street, Milwaukee.

Jules Chase, Wood, to 536 West Wisconsin Avenue, Milwaukee.

F. F. Bowman, Madison, to R. 1, Waunakee.

M. V. Grabiec, West Allis, to 139 Albert Street, Buffalo, New York.

M. R. Aguirre, West Allis to 1951 South 92nd Street, Milwaukee.

G. H. Spurbeck, Denver, Colorado, to Pierre Clinic, Pierre, South Dakota.

A. J. Schramel, Milwaukee, to 1422 Washington Heights, Ann Arbor, Michigan.

E. F. Peterson, Wauwatosa, to R. R. 2, Box 17, Oconomowoc.

Harry Horwich, Milwaukee to 5501 North Bernard Avenue, Chicago.

H. B. Haley, Seattle, Washington, to 48 Holden Road, West Newton, Boston, Massachusetts.

L. J. Seward, Berlin, to 251 East Newman Avenue, Arcadia, California.

L. F. Heise, Oshkosh, to Tigerton.

R. C. Heen, Milwaukee, to 1029B San Antonio Drive, Long Beach, California.

R. F. Schilling, Madison, to Thorndyke, Memorial Laboratory, Boston City Hospital, Boston, Massachusetts.

Leonard Elkind, Michigan, to 3415th Station Medical Squadron, Lowry Air Force Base, Denver, Colorado.

J. R. Matt, Parkersburg, West Virginia, to 411 East Mason Street, Milwaukee.

R. G. Piaskosksi, Milwaukee, to V. A. Hospital, Wood.

MARRIAGES

Dr. Timothy R. Murphy to Miss Jeanne Fleury, Milwaukee, on October 21.

Dr. Florian J. Ragaz to Miss Margaret Ledbetter, Madison, on September 23.

DEATHS

A. J. PATEK

Dr. Arthur J. Patek, widely known Milwaukee physician and a past president of the State Medical Society of Wisconsin, died at a Milwaukee hospital on October 12. He would have been 82 years old on November 11.

A native of Milwaukee, Doctor Patek was born on November 11, 1868. He was graduated from Johns Hopkins University and the University of Pennsylvania Medical School. Following internship in Philadelphia, he studied in Berlin and Vienna before entering practice in Milwaukee in 1896. During World War I he served as a medical officer in the Army Medical Corps, with the rank of captain. Until World War II he was a prefect for the University of Wisconsin Medical School.

Doctor Patek, one of the founders of *The Wisconsin Medical Journal*, described the beginnings of this venture in an article in the October 1950 issue of the *Journal*, entitled "The Medical Journal Was Born." He served as president of the State Medical Society in 1913, and in 1935 was the recipient of its Council Award, the highest honor bestowed by the Society. He also served as president of the Medical Society of Milwaukee County and the Milwaukee Academy of Medicine. A diplomate

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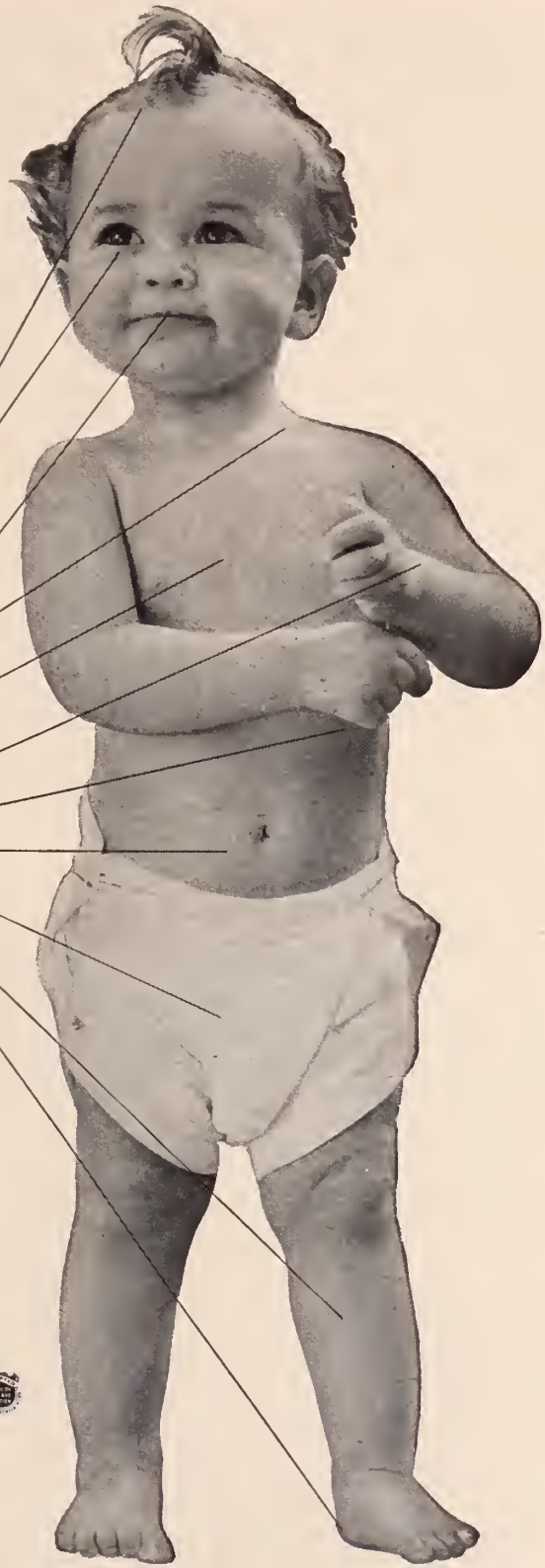

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of the American Board of Internal Medicine, he was a member of the American College of Physicians and the American Medical Association.

He was also an accomplished musician and was a director of the Milwaukee Orchestral Association.

Surviving are his wife, two daughters, and a son, Dr. Arthur Patek, Jr., of Cleveland, Ohio.

Dr. Maxon E. Margoles, Milwaukee physician, died at a hospital in that city on October 8. The doctor was 44 years old.

Doctor Margoles was born in Russia on February 5, 1906. He was brought to the United States by his parents when he was a year old and came to Milwaukee from Lawrence, Massachusetts, with his parents in 1917. He was graduated from the University of Wisconsin Medical School in 1930, interning at Mount Sinai Hospital. He had been a member of the attending staff at Mount Sinai Hospital, Milwaukee, for many years.

His wife and two daughters survive.

Dr. Gideon Benson, a doctor in Richland Center for nearly half a century, died at a Chicago hospital on September 26. He was 83 years old.

The doctor was born in the town of Forest in Richland County on December 16, 1866. Before entering medical school, he graduated from the University of Wisconsin and served as a teacher and as principal at the Richland Center High School. He received his M. D. degree from Rush Medical College in 1904 and returned to Richland Center to practice. During World War I he served as a captain in the Army Medical Corps. For the past two years he had been Richland County coroner, and he had served on the boards of education of both the Richland County Normal and the public schools. At the time of his death he was president of the Richland Center School Board. The doctor was the health officer of the city of Richland Center as well as of the towns of Dayton and Marshall. He was also the local medical examiner of the Chicago, Milwaukee, St. Paul and Pacific Railroad.

Secretary of the Richland County Medical Society since 1918, with the exception of one year, during which he served as president, the doctor also held membership in the State Medical Society and the American Medical Association.

His wife and three sons, all of whom are physicians, survive.

Dr. Charles J. Coffey, Milwaukee physician for fifty-five years, died after collapsing in front of his home in that city on September 30. He was 80 years old.

A lifelong resident of Milwaukee, the doctor was born on July 15, 1870. He received his degree in medicine from New York University Medical College in 1894, and in 1900 joined the staff of the Milwaukee College of Physicians and Surgeons. The latter was absorbed by the Marquette University School of Medicine in 1911, and the doctor remained on the staff until 1936. At the time of his retirement, when he was named professor emeritus, he was head of the department of laryngology, rhinology, and otology. Assistant city health commissioner for twelve years, Doctor Coffey was a member of the school board from 1911 to 1923, serving as president in 1916.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife, a sister, and a brother, Dr. William L Coffey of Milwaukee.

Dr. Timothy J. O'Leary, an East Troy physician for more than forty years, died at a Milwaukee hospital on October 7. He was 69 years old.

Doctor O'Leary was born in Fond du Lac on July 4, 1881. He received his medical degree from the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1903, establishing a practice at Caledonia shortly afterward. In 1905 he took postgraduate work in Vienna, Austria, and the following year he spent in graduate study in New York. In 1906 he located in East Troy, where he continued in practice until his recent illness. He was a member of the staffs of Burlington Memorial Hospital, Burlington, and Lakeland Hospital, Elkhorn.

The doctor was a member of the Walworth County Medical Society, the State Medical Society, and the American Medical Association.

His wife and a daughter survive. He was preceded in death by a daughter, Dr. Mary O'Leary in 1941.

Dr. William F. Wilker, physician at Iola since 1929, died suddenly in his office in that community on September 30. He was 47 years old.

The doctor was born on August 16, 1903, in Wyoming, Iowa. He received his medical degree from the University of Iowa College of Medicine in 1928, interning at the Metropolitan Hospital, New York. He also took postgraduate work in surgery at the Lennox Hill Hospital, New York, before moving to Iola in 1929. In that community he served as president of the Iola Hospital Association.

Doctor Wilker was a member of the Waupaca County Medical Society, the State Medical Society, and the American Medical Association.

His wife, a daughter, and three sons survive.

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Yours very truly,
(s) J. G. BARR

Tryon, North Carolina
October 28, 1950

Dear Sir:

Thank you ever so much for your letter of the 12th and for the "Fifty Year Pin." Some days later the "certificate" also came. Please also extend my appreciation to the proper "body" for having taken this action. I am very sorry that I could not be present at the dinner of the Fifty Year Club, but 800 miles away is a definite handicap.

I have not definitely decided whether to transfer to the North Carolina Society; yet I surely wish to continue my fellowship in the A. M. A. I am keeping up my non-resident membership in the Chicago Medical Society, which I joined in about 1901 or '02, while intern in the Cook County Hospital. Warm regards.

As ever,
(s) DAVID WENSTRAND, M. D.

New York, New York
October 17, 1950

Gentlemen:

May I take this opportunity to express my appreciation and sincere thanks to the officers and members of the State Medical Society of Wisconsin for allowing me to participate in your Scientific Meeting in Milwaukee, October 1st to 4th.

I was greatly impressed with the efficient management and the scientific skill with which your Society operates.

The reception from your President and President-Elect, as well as your other important officers, the hospitality, the interesting meetings, the fine exhibits, and the entertainment, all were beyond expectations, which made my visit so pleasant and one long to be remembered.

New acquaintances, as well as renewed friendships, were so worthwhile, and played such an important role in making my visit so enjoyable. One can readily understand that the important position held by the Wisconsin State Society in the national medical affairs only follows because of the type of leaders and members your Society is so fortunate to possess.

I indeed enjoyed myself, and I think benefited by the experience of watching your executive department in action.

Yours very truly,
(s) CHARLES W. MUELLER, M. D.
President
Medical Society of the County of Kings

Fond du Lac, Wisconsin
October 28, 1950

Dear Sir:

The pin together with my certificate of membership in the "Fifty Year Club" of the State Medical Society which you sent me recently came through in good condition. Sorry I was unable to be at the meeting this year, but sincerely hope to make it next year.

Naturally I am thankful for having survived fifty years of service in my chosen profession. And even though the going was rough occasionally and the strain was at times very severe I always enjoyed my work—am still at it and as interested as ever in the continuous progress being made in every field.

I want to thank you for the trouble you were put to because of me and the State Medical Society for the honor bestowed on me.

Gratefully yours,
(s) C. W. LEONARD, M. D.

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The Journal Bookshelf

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All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal* "Bookshelf," are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Operative Technic in Specialty Surgery. Edited by Warren H. Cole, M. D., F. A. C. S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago. Introduction by Allen O. Whipple, M. D., F. A. C. S. New York, Appleton–Century–Crofts, Inc., 1949. Price $14.00.

This is the second of a two volume series on surgical technic. In this volume the specialties, including plastic surgery, chest surgery, orthopedic and neurosurgery, gynecology, and urology are taken up. These various sections are written by men outstanding in their respective fields. There is a wealth of information in this book, and the chief criticism is that too much material has been presented too briefly. Consequently, the book suffers by lack of detail. The book is well bibliographed and the illustrations are revealing and excellent. The book would have no use for men already specialized in the respective fields which this book covers, but it would be of value to the well trained, experienced surgeon who could perform some of the simpler technics presented in this book. Because of the highly specialized nature of the material presented, this volume probably has no place for the general practitioner except that the general principles as outlined in the book might be of value in making him a more rounded diagnostician.—B. W. M.

Breast Deformities and Their Repair. By Jacques W. Maliniac, M.D., clinical professor of plastic reparative surgery and associate attending plastic reparative surgeon, New York Polyclinic Medical School and Hospital, New York City; attending plastic surgeon, Sydenham Hospital, diplomate, American Board of Plastic Surgery. New York, Grune & Stratton, 1950. Price $10.00.

This rather small volume deals mainly with the surgical indications and technic in the treatment of ptosis and hypertrophy of the female breast. There are rather brief introductory chapters on the history of mammaplastic procedures and on embryology and physiology of the breast. Because of the surgical importance in plastic procedures, the anatomy, especially the blood supply, of the breast is thoroughly discussed. The author presents the surgical indications and contraindications and explains the evolution of the procedure of transposition and mammectomy with and without free transplantation of the nipple. He gives a critical analysis of the classical and contemporary technics and presents his one and two stage methods of mammaplasty in detail, with many diagrams, illustrations, and preoperative and postoperative pictures. There are also chapters on the treatment of other anomalies of the breast, such as a polymastia, asymmetry, and nipple deformities, as well as a discussion of gynecomastia.

The author achieves his stated purpose of presenting a complete and accurate commentary of the present status of mammaplastic surgery. His appraisal and selection of the worthwhile procedures are based on years of clinical experience with emphasis on due regard for the blood supply and cosmetic reconstruction. This book should be valuable to the surgeon with little experience in this field who is interested in mammaplastic procedures, because of the critical analysis of the various procedures and careful explanation of the acceptable technics.—J.T.M.

An Atlas of the Blood and Bone Marrow. By R. Philip Custer, M. D., director, Laboratories of the Presbyterian Hospital in Philadelphia; assistant professor of pathology, the University of Pennsylvania School of Medicine; consultant to the Armed Forces Institute of Pathology. Pp. 321 with 285 figures, 42 in color. Philadelphia and London, W. B. Saunders Company, 1949. Price $15.00.

This atlas is a presentation of the disorders of the blood and bone marrow. It is divided into two sections, the first briefly and concisely dealing with the hematopoietic system in its development and normal function. The blood constituents are described and normal values for blood and marrow aspirates are given for periods ranging from fetal to adult life. This provides a good background for the second section which is devoted to the primary hematopoietic disorders. These comprise the anemias, which

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include deficiency states, displacement of marrow, hypersplenism, hemolytic anemias, ill defined anemias, hemorrhagic states, and effects of physical and chemical agents. Leukemoid reactions, infections, the leukemias, and polycythemia vera are also discussed. An enlightening chapter with plates on good and bad technics brings the book to a close.

This is in no sense a text of hematology; rather it is a brief, concise presentation of the primary blood disorders, listing the important clinical findings and additional laboratory tests that are indicated. Treatment is discussed when it has a bearing on the diagnosis.

Equally important and supplementing the text for almost all diseases presented are plates of the blood, of marrow aspirate and marrow sections. These plates are uniformly good, as is the photography. Particularly excellent are the colored and black and white plates for pernicious anemia, sprue, histoplasmosis, and hemolytic anemia; less effective are those for infectious mononucleosis. This difference is understandable, for the material comes from many sources and variations in preparation and staining methods are probably accountable.

Classification of diseases with tables of important data is well incorporated, and different concepts on etiology and cell maturation are discussed, the author giving his choice or simply stating his own opinion. The newly standardized terminology is used throughout with the exception of the red cell series. The absence of a bibliography in no way detracts, for, wherever indicated, footnote references are given. The format is good although this reviewer thinks that the paper is too glossy. The print is easily read and the binding is sturdy and durable.

The arrangement of the material, simplicity of text, the unique combination of blood, marrow aspirate, and tissue plates brings out very ably and clearly the author's purpose: to promote "more accuracy of diagnosis." This atlas is highly recommended and should be of value to the clinician, pathologist, and hematologist, besides having a definite place in libraries for student use.—E. T.

The Eye and Its Diseases. By 92 international authorities. Edited by Conrad Berens, M. D., F. A. C. S. Second edition. Pp. 1092, with 436 figures, 8 in color. Philadelphia and London, W. B. Saunders Company, 1949. Price $16.00.

The second edition of the book "The Eye and Its Diseases" has been overdue because of the many changes in ophthalmology that have taken place since the first edition of 13 years ago. The second edition has been extensively revised, but not lengthened. The pages are printed in double columns, making for easier reading. This decreases the number of pages by 162. A few additional illustrations are used. New drugs and technics are discussed, and a new chapter on gonioscopy has been added.

Doctor Berens' book will continue to fill a definite need in the ophthalmic field for both students and practitioners.—P. A. D.

The Salt-Free Diet Cook Book. By Emil G. Conason, M. D., and Ella Metz. New York, Lear Publishers, Inc., 1949. Price $3.00.

The introduction gives an excellent review of the basic physiology of sodium balance and the historical use of low sodium diets. The authors have put a tremendous amount of work into the preparation of recipes and menus for low sodium diets, but present little evidences of the application of their knowledge of food processing or of the basic principles of nutrition.

No mention is made of softened water as a possible source of considerable sodium, although mention is made of the variable sodium content of local water supplies. No mention is made of the commercial use of sodium compounds in the preparation of fruits for canning or drying, or the widespread use of sodium chloride in the preparation of vegetables and certain fruits for freezing, although the patient is warned to avoid canned fruits if sodium benzoate has been added. Federal labelling standards do not demand this type of informative labelling, so the patient would have no way of knowing whether or not sodium benzoate had been added. A list of classes of foods in which one might suspect the

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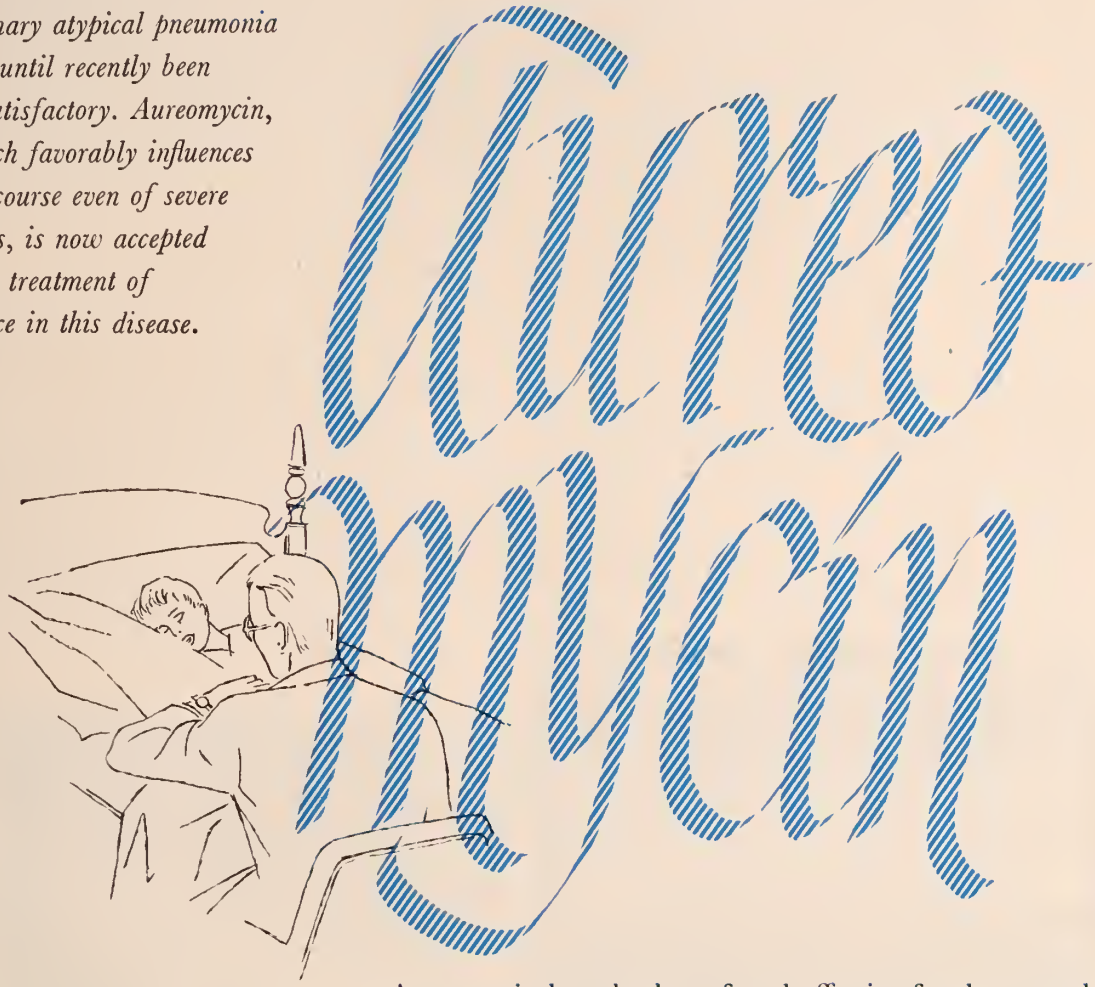

Aureomycin has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, acute brucellosis, common infections of the uterus and adnexa, resistant gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), tularemia and typhus.

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presence of sodium benzoate would be helpful. No mention is made in the recipes of the use of only the so-called "salt free" (without added sodium chloride) bread, butter, canned vegetables, or fish when these items are used.

No basic menu pattern with possible food choices is outlined for the patient. The menus presented in detail show little evidence of use of N. R. C. standards. A food source of vitamin C has usually been planned each day, but other nutrients are low. The milk allowance is alarmingly low for any therapeutic diet. No mention is made in the recipes or menus of the low sodium milks on the market. Protein foods are not well distributed over the day's meals. Several luncheon menus have no food of appreciable protein value. Over half of the luncheon menus feature eggs in some form—the egg recipes are very interesting. The total protein content of the menus is low.

No apparent attempt has been made to correlate the low sodium menus with the food the family would be eating. With such emphasis on the "special" aspects of the diet there would be grave danger of making the patient a low sodium invalid. Wisely planned special diets can be the avenue to better nutrition through emphasis on the wise selection of foods. The "Salt-Free Diet Cook Book" makes little attempt to set a pattern for wise food choice.—R.S.D.

The Development of Gynaecological Survey and Instruments; a Comprehensive Review of the Evolution of Surgery and Surgical Instruments for the Treatment of Female Diseases from the Hippocratic Age to the Antiseptic Period. By James V. Ricci, M. D., clinical professor of gynaecology and obstetrics, New York Medical College; attending gynaecologist, City Hospital, New York; consultant in gynaecology and obstetrics, Beekman–Downtown Hospital; Director of gynaecology and obstetrics, Columbus Hospital. Philadelphia and Toronto, The Blakiston Company, 1949. Price $12.00.

This is, truly, a comprehensive review of the historical background of gynecologic surgery and gynecologic instruments. It is assembled in an orderly manner covering the period of time as included in the subtitle. The references at the end of each chapter are extensive and inclusive.

This text can be recommended as very enjoyable historical reading as well as for its value as an historical reference book in gynecology.—M. J. T.

A Century of Medicine in Jacksonville and Duval County. By Webster Merritt. Gainesville, University of Florida Press, 1949. Price $3.50.

This book covers the medical history of Jacksonville, Florida, during the nineteenth century. It contains portrait sketches of the outstanding local physicians of the period, descriptions of the first hospitals, and the founding of professional societies. Unlike most local medical histories which are limited

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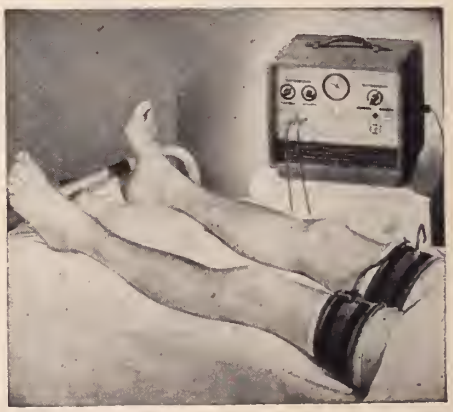
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to such routine items, this book reports not only on doctors but also on diseases. It reviews the epidemics constituting the main health problem in Jacksonville, especially those of small pox and yellow fever. The book ends with the conquest of the latter plague through better sanitation and founding of a State Board of Health in the last decade of the nineteenth century. It is well written and well illustrated.—E. H. A.

Essentials of Obstetrical and Gynecological Pathology. By Robert L. Faulkner, M. D., F. A. C. S., assistant professor of gynecology, the Western Reserve Medical School; Associate gynecologist, University Hospitals of Cleveland, Ohio; and Marion Douglass, M. D., formerly assistant professor of gynecology, the Western Reserve Medical School. With 300 illustrations, including 3 color plates. Second edition. St. Louis: The C. V. Mosby Company, 1949. Price $8.75.

This is the second edition of this textbook which concerns itself exclusively with the pathology of the female generative tract. It is concise and condensed but presents in a simple, direct way the essentials necessary for instruction of medical students and the younger members of hospital staffs obtaining specialty training in obstetrics and gynecology.

The text has been revised and brought up to date. The illustrations are excellent.—M. J. T.

The Physiology of Thought: A Functional Study of the Human Mind in Action. By Harold Bailey, M. D., F. A. C. S. New York, The William-Frederick Press, 1949. Price $3.75.

In this book, Doctor Bailey presents his conception of mind and his ideas about how the mind works. He seeks to erect an understanding of the mind based upon the physiologic concept of function. His thesis, in summary, runs as follows: Thought is the specific function of the cells of the cerebral cortex, and the author speaks and treats of thought as though it emanated from the thought cells in some determinate manner like a secretion from the cells of a gland. Thinking is said to be a continuous function of the cortical cells, but it varies in accordance with the amount of thought cell stimulation present. The thought cells, in turn, are stimulated by special sense impressions, and the number and intensity of these special sense impressions determine the amount of thought that goes on at any given time. Memories and consciousness are but the products of thought and are not functions in themselves. Memories are said to be the basis of habit, and instincts are merely inherited memories. Emotions are regarded as the physical reactions resulting from thought imbalance, and they are considered by the author to be injurious to health. The manifestations of neurasthenia (a term which appears to cover all nervous and mental diseases) are evidences of thought cell fatigue and are due to "health impairment combined with thought perversion or excess . . ." The author never makes clear what controls thought or what causes imbalance or perversion. In the final portions of the book, the author is concerned with the differentiation of consciousness and life, and he concludes with the statement that they are both products of the function of thought.

Doctor Bailey's book is not an easy book to read. His prose style consists for the most part in a series of declarative statements and simple assertions unrelieved by qualifying or clarifying clauses. Definitions are few, and the author uses important words such as thought and emotion in several different senses. His line of reasoning is difficult to follow and often seems based on false premises or just simple reasoning in a circle. In addition, the book is replete with statements that are, in the light of modern psychology, just not so. For example, while thinking is certainly dependent upon the integrity of the cerebral cortex, it is not in any sense a direct emanation or specific function of individual nerve cells. Further examples: Emotion is not dependent upon thinking and is not injurious to health; neurasthenia is not due to nerve cell fatigue, memories cannot be inherited, etc.

For a book purporting to present a new conception of mind, however, its most serious shortcoming is its complete lack of evidence for conclusions drawn. Nowhere in the book is any evidence of a scientific or testable nature mentioned. No experimental evidence from the fields of physiology or psychology is referred to; nor does the author even mention any research of his own. The thesis and argument of this book depend entirely on speculation and dubious reasoning from questionable premises. The conception of mind presented is consequently, in the opinion of this reviewer, largely in error and of little value to the serious worker in psychology, physiology or medicine.—O. O.

Allergy in Relation to Otolaryngology. By French K. Hansel, M. D., M. S., F. A. C. A., editor-in-chief, Annals of Allergy; director of The Hansel Foundation; associate professor of otolaryngology, Washington University School of Medicine. An official publication of the American College of Allergists. Saint Paul and Minneapolis, 1949, Bruce Publishing Company, 1949. Price $2.50.

"Allergy in Relation to Otolaryngology" presents an effort to correlate the inter-related problems of the otolaryngologist and allergist. In the text Doctor Hansel discusses symptomatology, rhinoscopic

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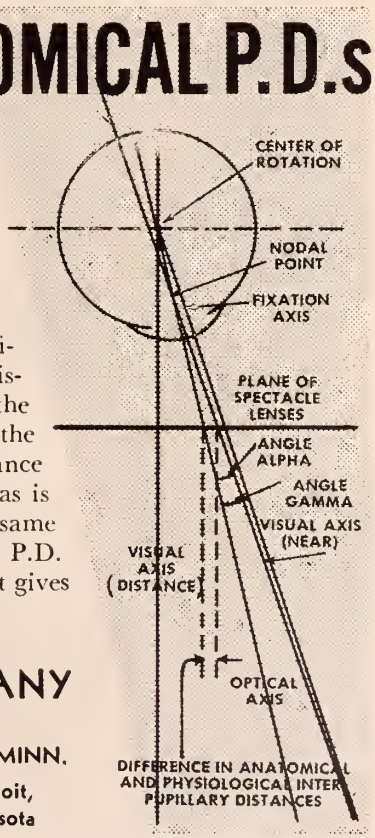

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Of particular note is the section devoted to microscopic examination of nasal secretions, in which Doctor Hansel discusses his stain technic and attempts to classify the cytologic response in terms of allergy, infection, and varying combination of the two. The color plates accompanying this section are excellent.

The author states that "The allergist must have the opinion of an otolaryngologist who can evaluate the complicating pathologic changes in the nose and paranasal sinuses and in the tracheobronchial tree." He further advises that "Although there are many instances in which some form of surgical intervention is indicated, a conservative approach to the problem should be practised, because satisfactory end results are more dependent upon adequate allergic management rather than operative interference."

In emphasizing and evaluating the necessity for a close cooperation between these two specialists to insure adequate treatment of allergic patients, this book can be expected to receive a wide professional acclaim.—C. R. T.

Manual of Medical Emergencies. By Stuart C. Cullen, M. D., professor of surgery and chairman, division of anesthesiology, State University of Iowa College of Medicine; and E. G. Gross, M. D., professor and head of department of pharmacology, State University of Iowa College of Medicine. Chicago, The Year Book Publishers. Inc., 1949. Price $3.75.

This is a concise, easily read, and well organized guide to the management of medical emergencies. The chapter on airway and artificial respiration is particularly well written. The management of circulatory emergencies is logically outlined and fairly completely covered, considering the limited scope of the book. The discussion of local anesthetic reactions is particularly commendable. This manual can be highly recommended to the general practitioner as well as a specialist who is called on to cope with a variety of emergency situations.—A. B. W.

Cardiovascular Disease; Fundamentals, Differential Diagnosis, Prognosis and Treatment. By Louis H. Sigler, M. D., F. A. C. P., attending cardiologist and chief of cardiac clinic, Coney Island Hospital; consulting cardiologist, Rockaway Beach Hospital; consulting cardiologist, Menorah Home and Hospital for the Aged. New York, Grune and Stratton, 1949. Price $10.00.

This is another of the recent good books on cardiovascular disease. Succinctly written and practical, it uses the case presentation method liberally to illustrate the wide range of disease entities. Especially well done and illustrated are the diagnostic criteria. The handling of the psychosomatic aspect deserves special attention.

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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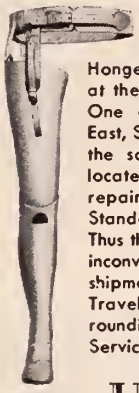

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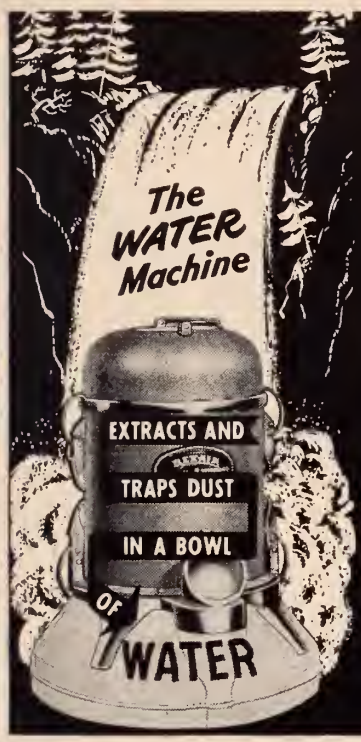

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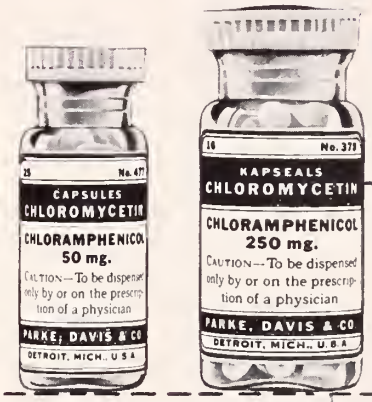

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1. Gordon, E. S.: Nutritional and Vitamin Therapy in General Practice, Year Book Pub., 3rd ed., 1947. 2. Manchester, T. C.: Food Research, 7:394, 1942. 3. McLester, J. S.: Nutrition and Diet, Saunders. 4th ed., 1944. 4. Rose, M. S.: Rose's Foundation of Nutrition, rev. by MacLeod and Taylor, Macmillan, 4th ed., 1944. 5. Sherman, H. C.: Chemistry of Food and Nutrition, Macmillan, 7th ed., 1946.

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1. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 5th ed., 1946, 704-705.
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Case report abstracted from: King, E. Q. et al.: J.A.M.A. *143*:1 (May 6) 1950.

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1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J.A.M.A. *143*:1 (May 6) 1950.
2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. *25*:183 (Apr. 12) 1950.

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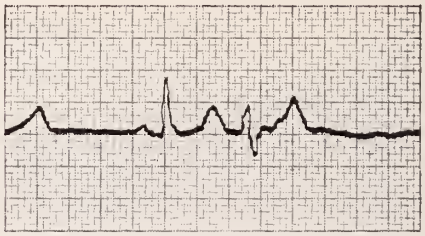
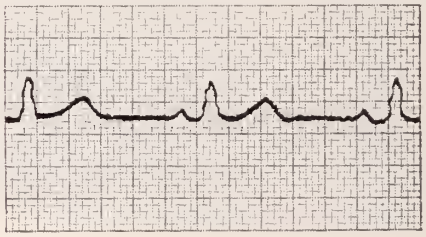
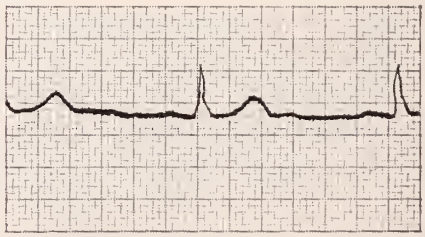


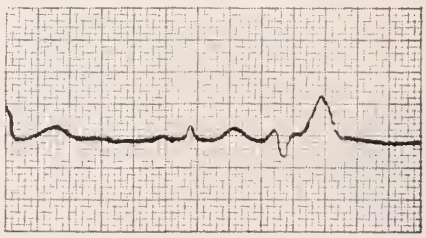
Lead II. Tracing 30 minutes after 1 Gm. Pronestyl orally. No ventricular premature contractions present.



Lead II. Tracing 7½ hours later shows persistent effect.



Lead II. Tracing 24 hours later shows return of ventricular premature contractions.



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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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Cystic Dilatation of the Ductus Choledochus

By JOSEPH W. GALE, M. D. and MARVIN G. PETERSON, M. D.
Madison *Lake Mills*

J. W. GALE

Professor of surgery at the University of Wisconsin Medical School, Doctor Gale received his medical degree from the Washington University School of Medicine, St. Louis, in 1924. He took surgical training at Barnes Hospital, St. Louis, and in 1927 became associated with the University of Wisconsin Medical School. During World War II he served with the Army Medical Corps.

CONGENITAL, cystic, or idiopathic dilatation of the common bile duct is extremely rare. It has been encountered only once at the State of Wisconsin General Hospital in 25 years and in over 3,000 cases of gallbladder disease. Rogers and Priestly[1] state that only 1 such case was seen in the Mayo Clinic in 20 years. These authors, in reporting the second case, in 1949 included an extensive review of the literature, in which they found 175 cases. For the sake of brevity no further references will be quoted. Those interested may refer to the above-mentioned report for a comprehensive bibliography.

Report of a Case

A white girl, aged 15, first seen by one of us (M.G.P.), entered the Wisconsin General Hospital, Nov. 7, 1949, with a chief complaint of stomach trouble. History of the present illness extended over a period of six years. During this period the patient said she had had gas-like pains in the epigastrium which occurred about three times each year. The distress usually began after midnight and was relieved by projectile vomiting of food taken the evening before. She had noticed a relationship of the attacks to the eating of sweets, popcorn, and ice cream, but not following the eating of fried, fatty, or acid foods. On Sept. 1, 1949, she had one of her most severe attacks. This attack occurred soon after the evening meal, when a sharp, nonradiating pain developed around the umbilicus. She had eaten dinner rather rapidly and was excited about going out. The pain stopped spontaneously in about one hour. The next morning she wakened with a dull pain in the epigastrium which radiated along both costal margins, and the pain was aggravated by deep breathing. She also noted a dull pain in both sacral regions. This pain remained constant, and on the fifth day she vomited curdled milk soon after she had taken it by mouth, but this did not give her any relief. On the seventh day following the onset of her attack she again vomited what she thought to be blood, about 1 cupful, and was completely relieved of her pain and had remained free of pain since. Demerol, which was administered by her physician (M.G.P.) on the second day of this attack, did not give her any relief. She had never noted any evidence of clay-colored, bloody, or tarry stools, nor had she been relieved following a bowel movement. Skin and sclerae were slightly icteric on the seventh day of the attack. There had been no associated chills, fever, diarrhea, or constipation. On several occasions she received relief through the application of a heating pad to the abdomen.

History of previous illnesses revealed very little except that the patient had worn glasses for the past three years. There was some decreased hearing in the right ear, which had persisted following an ear infection shortly after an attack of measles at the age of 13. About one year previously there had developed a nocturia three times per night, lasting over a period of two months, but this subsided spontaneously. During the past few months she had had some sacral pain, relieved by urination. There was no history of pyuria, dysuria, or hematuria. Catemenia onset was at 13 years, every 25 to 28 days, lasting seven to eight days. There had been no dysmenorrhea until the last period, which had begun Nov. 4, 1949. Weight at the present time was 127 pounds. There had been no recent loss of weight.

Physical examination revealed a young, slender white female of about her stated age who entered the hospital in no acute distress. Temperature was normal, pulse rate 80, respiratory rate 18, and blood pressure 116/78. There were no important physical findings on examination. The abdomen, in particular, was slightly scaphoid in type and soft, with no tenderness, masses, or induration palpable. Otherwise the physical examination was negative. Impression at this time was Meckel's diverticulum, chronic appendicitis, or peptic ulcer.

Laboratory.—The urinalysis was normal. The blood cell count showed a hemoglobin content of 14.6 Gm., 4,890,000 red blood cells, and 5,700 white blood cells; the differential blood cell count was normal. Blood chemistry showed a blood sugar level of 90 mg. per hundred cubic centimeters and nonprotein nitrogen content of 23 mg. Gastric analysis showed free acid 29.5 degrees and total acid 62 degrees. The blood cholesterol level was 259 mg. The serologic reaction was negative. Gastrointestinal series revealed the esophagus to be normal. The stomach contained fluid and was atonic. There were no in-

trinsic defects. The duodenum filled readily and was considered normal. Small bowel studies showed a small residue of barium remaining in the stomach at the end of three hours, following which the patient was allowed to eat. Progress through the small bowel was quite good, and the meal was largely in the colon at the end of three hours. The duodenum remained atonic and somewhat dilated, but there was no evidence to show that there was an abnormal stasis in the duodenal segment. The conclusions were those related to atony of the upper gastrointestinal tract, but no evidence of organic disease. Barium enema revealed a normal colon and terminal ileum. On a cholecystogram a shadow of the gallbladder could not be identified. It apparently had concentrated no medium and was considered nonfunctioning. No radiopaque stones were visualized. (Two earlier cholecystograms gave similar results.)

In view of the history it was felt that an exploratory laparotomy was justified. The gastrointestinal series had added nothing to enable an exact diagnosis. On Nov. 14, 1949, the abdomen was explored through an upper right rectus incision. The liver was normal to inspection. Palpation of the pelvic organs, the stomach, the spleen, and throughout the peritoneal cavity revealed no abnormalities. On exposure of the gallbladder it was noted to be slightly enlarged. The wall showed some thickening; otherwise, grossly there were no pathologic changes. On inspecting the region of the common duct a mass was palpated which was about 6 cm. in diameter (fig. 1). On incising the posterior parietal peritoneum and exposing this mass, it was found to involve the common duct. The upper portion of the mass was dissected free and the common duct was found entering the mass after the bifurcation of the right and left hepatic ducts, and entering the posterior surface of the cyst. Aspiration of the cyst confirmed our diagnosis of a choledochus cyst and the cyst was opened longitudinally. Within the cyst were four very soft, gelatinous-like dark green stones about 0.5 cm. in diameter (fig. 2). These were removed.

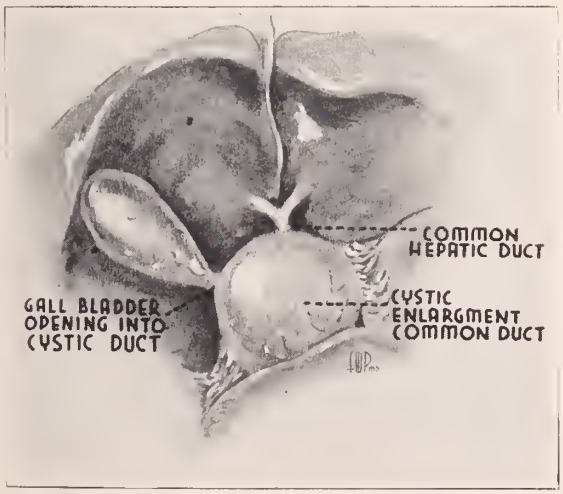

Figure 1

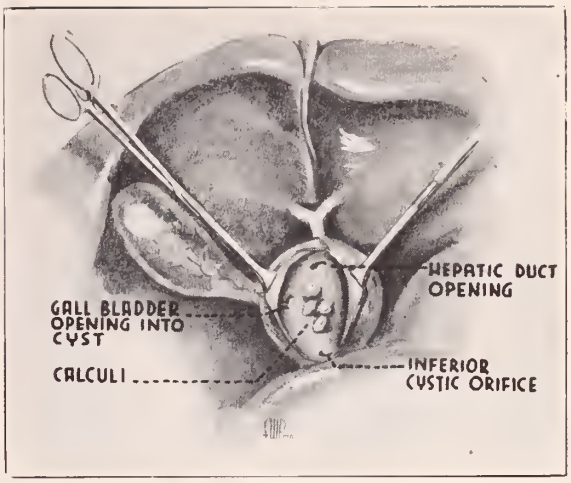

Figure 2

On further exploration we found a small opening entering the superior and posterior aspect of the cyst. An 8 mm. probe could be inserted in this very easily and pushed upward and into the right and left hepatic ducts. On examining the inferior portion of the cyst after it had been dissected free from the anterior portion of the duodenum and drawn upward, a small opening, which would admit a 4 mm. probe, was seen at the lower pole of the cyst. This probe, when passed through the opening, entered the duodenum without difficulty. This was gently dilated up to 6 mm. On further inspection it was found that the cystic duct entered the anterior and right wall of the cyst. Since there was an adequate communication entering the cyst and an adequate exit into the duodenum, it was thought advisable to excise the anterior wall of the cyst and reconstruct the wall into a common bile duct. This was done. It was necessary to sacrifice the gallbladder, which had been proved to be functionless, along with the cystic duct, which joined the anterior wall of the cyst. Following the excision of the cyst wall, a T–tube was placed and the wall of the cyst was sutured over the T–tube with interrupted sutures of 000 catgut (fig. 3.) After completion of the suture the duct was about 1 cm. in diameter. The gallbladder was then removed in the routine manner. The gallbladder bed was closed. A cigaret drain was inserted alongside the T–tube and allowed to protrude through the upper end of the wound. The wound was then closed in layers around the T–tube and drain.

The postoperative course was essentially uneventful. The patient was not ambulated until the third day because of the T–tube, which was connected with a bottle beside the bed. During the first five days after operation the patient continued to have very slightly bile-stained stools, almost clay-colored. There was a copious drainage of bile through the T–tube during this period. On the seventh postoperative day, after a cholangiogram had been performed on the sixth postoperative day, the T–tube was clamped. The cholangiogram had shown the newly constructed common duct to be well outlined by the

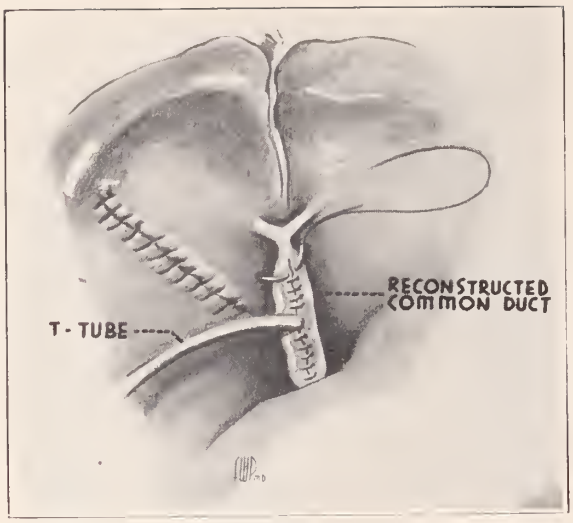

Figure 3

medium, although there was poor visualization of the radicles of the duct. The common duct appeared dilated as expected following the plastic operation, but there were no filling defects in the newly constructed duct and there was an immediate flow of the medium into the duodenum. On the tenth postoperative day, after the T–tube had been clamped for 48 hours, it was removed. Following this there was a rather copious flow of bile for 12 hours. This had entirely ceased at the end of 24 hours. Bile appeared in the stools which were darkly colored 24 hours after the T–tube had been clamped. Following removal of the T–tube the patient's appetite increased very rapidly, and she was discharged from the hospital on her twelfth postoperative day, Nov. 26, 1949. The patient has remained entirely well and free from symptoms since that date.

Incidence

This condition is encountered most frequently in the female and in the early decades. The ratio in the reported cases is 10–15 (female) to 1 (male).

Etiology

Although there are many theories, none appear to give the correct answer.

Symptoms

The condition has been encountered so infrequently that no pathognomonic signs and symptoms have been established. It is interesting to note that pain, tumor mass, and jaundice have been the most frequent. These, however, can readily be confused with gallbladder disease.

Pathology

Grossly all these cases are more or less similar: the presence of a spherical cystic tumor lying retroperitoneal, below the liver in the region of the common bile duct, anterior or posterior to the duodenum. The gallbladder may or may not show disease. Microscopically, the cyst wall may show intact mucosa or it may show only fibrous tissue surrounding smooth muscle fibers. If acute, many polymorphonuclear cells will be present. If chronic, there is lymphocytic infiltration.

Diagnosis

Since there are no typical symptoms present, one would expect diagnosis to be difficult. This is true. Rogers and Priestley[1] report that in 175 cases the correct diagnosis was made or thought of in only 22 (12.6 per cent).

Treatment

Rogers and Priestley report that in the 175 compiled cases 148 patients received surgical care, with a mortality of 51 per cent. The type of operation performed varied from simple aspiration and drainage to some type of anastomosis between the cyst and a contiguous organ. The high mortality has been reduced with a better understanding of the condition coupled with better technic. No definite procedure can be advised. The type of operation to be carried out will depend upon the problem at hand. Rogers and Priestley in their case found the exit from the cyst into the duodenum too small and were forced to perform a Roux type of anastomosis of the jejunum with the cyst. Just how small the opening of exit can be and still remain adequate is unsettled. In our case the opening was 4 mm., easily dilated to 6 mm. So far this has proved adequate.

Summary

A case of a very rare condition has been reported, with the idea that if encountered by others for the first time the problem will appear less puzzling.

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UNIVERSITY OF MINNESOTA TO PRESENT CONTINUATION COURSE

The University of Minnesota is presenting a continuation course in ophthalmology for doctors of medicine specializing in this field at the Center for Continuation Study January 22–26, 1951. Dr. Alson E. Braley, professor and head of the department of ophthalmology, University of Iowa, and Dr. A. D. Ruedemann, professor and head of the department of ophthalmology at Wayne University, Detroit, will be the visiting faculty members. The course is given under the direction of Dr. Erling W. Hansen, clinical professor of ophthalmology and director of the division of ophthalmology.

Suicide

Implications For the General Medical Man

By CARL L. KLINE, M. D.
Milwaukee

C. L. KLINE

Doctor Kline, a diplomate of the American Board of Psychiatry and Neurology, is in private practice in Milwaukee and serves on the staff of St. Mary's Hill Sanitarium. He was graduated from Northwestern University Medical School in 1941, and, following internship, entered the United States Navy. Following his discharge, he completed residency training in psychiatry at St. Elizabeth's Hospital, Washington, D. C., and Duke Hospital, Durham, N. C.

ONE of life's greatest tragedies is the suicide of a man or woman in the prime of life. Usually the person who commits suicide in the late forties or early fifties is an active, productive, successful man with a wife and several children. Friends, relatives, and the newspaper readers are puzzled that a person should end his own life in such a way. It often appears that the deceased had "everything to live for." Why then did he destroy himself?

The general medical man is sometimes confronted by a patient around 50 years of age who complains of sleeplessness, anorexia, general malaise, some loss of weight, and general loss of the sense of well-being. Usually it will also be revealed that the patient feels depressed and has feelings of guilt and unworthiness. Such a patient will fail to reveal significant related pathology to the physical examination, x-ray, and laboratory procedures. The patient will usually fail to respond to rest, sedation, tonics, and hormones. Many such patients will get well spontaneously in from nine months to two years. However, many will remain sick for longer intervals, and a few will seek self-cure through suicide. It is this danger which concerns us here.

General Facts About Suicide

In all causes of death suicide stands ninth. It is nearly twice as common as homicide and accounts for more deaths than the five most common communicable diseases.[1] In 1947, suicide accounted for 11.2 deaths per hundred thousand population, as compared with 23 deaths per hundred thousand population due to motor vehicle accidents. It is probable that many actual suicides are not reported as such. In 1933 Dublin gave a minimal estimate of 310,000 suicides a year throughout the world. Compare this figure with the 304,000 total dead and missing of the United States Armed Forces during World War II.[2]

The suicide rate increases with advancing years. Children rarely commit suicide, but, beginning with adolescence, each decade shows a steady and consistent rise. Statistics show that more than half of all suicides occur in persons 45 years of age or older. Annually three times as many men as women commit suicide.[3] Men more commonly utilize more aggressive means of achieving their end, such as shooting or jumping off buildings. Women are apt to seek more passive measures, such as taking poison or gas.

Some Misconceptions About Suicide

Many misconceptions are abroad in reference to the cause and meaning of suicide. St. Augustine was the first to designate the act of suicide as a sin. It continues to be regarded as a shameful act, so that many people cover up suicide in the family, much as they hide criminality. Doctors often collaborate with the family in this respect, and this produces a real error in the statistics on suicide.

The general belief is that one must be insane in order to commit suicide. Although this provokes a philosophical discussion, case material indicates that it is simply not true. Many patients have been examined by competent, experienced clinicians shortly before they committed suicide, and no evidence of insanity was found.

Another prevalent belief, even among psychiatrists, is that suicide is restricted to depressed patients. The incidence of suicide in schizophrenia, the various neuroses, and in patients without a definitive psychotic condition betrays the falsity of this belief. In addition, data in reference to suicide rituals in primitive tribes, and in certain cultures, deny the necessity for allying suicide with a specific mental state.

The adage that those who talk about suicide never commit suicide is pure nonsense, just as is a similar belief that those who fear "going crazy" never become psychotic. It is also untrue that one who has made an unsuccessful suicidal attempt will not repeat the attempt, although this may be true in the individual patient.

Perhaps the most common misconceptions are the "common sense" explanations offered so glibly by families, physicians, and the press. Some of these "common sense" reasons are: "despondent over ill health," "worry over finances," "an unsuccessful love affair," and "grief over loss of a loved one."

The salient fact that many others with such burdens to carry do not commit suicide raises the question as to what specific factors were present in the personality of the suicide victim. In addition, statistics show that suicide is less frequent in time of economic depression and higher in time of prosperity.[4] Such "common sense" reasons undoubtedly are often precipitating factors, but they are not the cause of suicide in any individual case.

Judging Suicidal Trends

Although a good deal is known about the psychodynamics of suicide, we are ignorant of the basic cause. This is comparable to cancer, a condition about which a good deal is known, but the cause of which is still being sought. Observations indicate pertinent factors in the personality of many patients who commit suicide. These factors should be known to the physician and, when present, should alert him to the possibility that his patient is potentially suicidal.

1. *Depression.*—The depressed patient is always potentially suicidal. This is particularly true of the man or woman in the involutional period, which includes ages 40 to 65. In this group of depressed patients, denial statements by the patient, refuting any thoughts of suicide, are not by any means a guarantee against the possibility; in fact, such statements may have the opposite meaning. If the patient looks and feels depressed, any of the following additional symptoms increase the suicidal danger: (*a*) sleeplessness, (*b*) hypochondriasis, (*c*) feelings of guilt, (*d*) feelings of unworthiness and failure, (*e*) loss of weight, (*f*) inability to work efficiently, (*g*) inability to concentrate, (*h*) memory difficulty, and (*i*) carelessness about appearance.

Many such patients go to the family physician because of the insomnia, anorexia, loss of weight, and general malaise. When such a patient is seen, a psychiatric consultation should be insisted upon. It is too late after suicide has occurred. This group of depressed patients comprises the largest group of potentially suicidal patients seen by the family physician.

2. *Elation.*—Patients with an elevated mood, excess energy, overtalkativeness, and playfulness may be in a mild or early manic episode and are to be considered much in the same category as the depressed patient. Such a patient may be on the upswing from a period of depression, a time which is especially dangerous from the suicidal standpoint; or the elevated mood may be the predecessor to a period of depression.

3. *Oral-Dependent Individuals.*—A potentially suicidal person may show a good deal of dependence upon others and may be dependent upon oral gratifications. The latter refers to such things as excessive drinking, excessive smoking, overeating, food faddism, and dependence on medicine and drugs.

4. *General Factors.*—If there is a history of the death of a beloved person at one of two periods in the patient's life, either at the age of 6 or at puberty, potentiality of suicide is increased.[1] There appears to be an increased danger of suicide in women during menstruation. It also appears to be true that there is a "mental infectious" factor in suicide, and the press reports on suicide have a deleterious effect upon emotionally ill persons.[5]

Many, if not most, people have occasional, fleeting suicidal thoughts, and such thoughts may go so far as the consideration of ways of accomplishing such an act. The fact is that most people do not commit suicide, so it becomes a matter of evaluating such thoughts in any one individual in terms of the emotional development of that individual. There is no easy formula for predicting whether a given individual will or will not commit suicide. Even the most experienced clinician will be fooled occasionally. But this does not negate the need to give careful consideration to every patient, in the light of what we do know.

The Medical Patient

The medical patient who fails to respond to treatment, going on into chronic illness or to death, is often an enigma to physicians. On the other hand, some patients show a strong "will to live" and get well in spite of seemingly overwhelming odds against them. Why is it that some patients are so easily embraced by illness, while other reject all of its advances? Is it that for some patients there is "nothing to live for" or that death is preferable to a meaningless life? What is behind the oft-quoted: "Ah, death, where is thy sting? O grave, where is thy victory?" and "Call no man happy till he is dead"? Many passages in classical literature poetically portray the advantages and beauty of death. All of this appeal of death must have significance—truth derived from deep human insight.

Many observations recorded in medical literature pertain to this lack of the will to get well and the will to live. Every observing physician sees this seemingly intangible factor at play in some of his patients. Often this factor can be understood in the light of today's knowledge of psychopathology, and often these patients can be helped in the light of this knowledge. The physician's understanding of this aspect of illness is often essential to the well-being of the patient. This may often be far more important than the blood cholesterol or the basal metabolic rate.

The Surgical Patient

In the minds of many patients, mutilation and death are equated. Certain patients with strong feelings of guilt and a need for punishment will attempt to satisfy such needs through surgical procedures. By means of unconscious mechanisms, such patients will often develop symptoms or disease which demands surgical intervention. Often such patients are surgical shoppers and have had multiple operations. Most surgeons are aware of these problems and are quite chary about approaching them sur-

gically. The indication for operation may, however, be so distinct that the surgeon has no choice.

Many patients who have a stormy postoperative course, far out of proportion to what could be expected, may be unconsciously utilizing the operation for emotional purposes. Patients who unwarrantedly die in surgical operations may be indirectly committing suicide. Dr. Karl Menninger cites the case of a woman who became pregnant for the first time rather late in life. Her pregnancy was uncomplicated and the labor not difficult, but she died. No explanation was available, and postmortem findings were not helpful. From relatives and friends it was learned that she had always associated pregnancy and death and that she avoided pregnancy. When she learned of her pregnancy she began informing her friends she would die in childbirth. She made all preparations for her death, including funeral arrangements.

Management of the Suicidal Patient

Suicide should be viewed as a reaction of a developmental nature rather than as an isolated incident in a lifetime. Often one can learn more about the suicidal patient from a glance into his childhood history than by a detailed analysis of his "despondency over ill health." Generally speaking, suicidal patients have always had difficulty in dealing with hostile impulses and aggressivity in general. Suicide results when a person turns these hostile, aggressive impulses upon himself.

Just as acute appendicitis is a surgical emergency and a coronary attack is a medical emergency, so is the suicidal patient a psychiatric emergency. Psychiatric evaluation of the patient is just as essential in the depressed patient as is sputum examination in the tuberculosis suspect. Both procedures may be life saving. The psychiatrist can evaluate the emotional factors in the patient and advise the physician of their significance, indicating what type of special management, if any, is indicated.

Many factors enter into a consideration of treatment of the depressed patient. Treatment must meet the needs of the individual patient. Dynamically oriented psychotherapy is the treatment of choice, but for selected patients, particularly in the involutional age group, electric shock therapy is often lifesaving. The responsibility for the treatment of such patients should be borne by the psychiatrist, just as surgical responsibility belongs to the surgeon. By working together, the medical man and the psychiatrist can rehabilitate many depressed patients and avert a significant number of tragedies.

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WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION OFFERS TWO TRUDEAU SCHOLARSHIPS

The Wisconsin Anti-Tuberculosis Association is again offering two free scholarships to Wisconsin physicians for the four week session of the Trudeau School of Tuberculosis, Saranac, N. Y. The tuberculosis course will be held from April 30 to May 26, 1951.

Those eligible for this thirty-seventh annual session are recent graduates of approved medical schools, with preference to physicians who have had some tuberculosis experience or who plan to specialize in internal medicine. The scholarship will pay $350 for each physician, to include tuition, transportation, and maintenance.

The subject matter of the course covers all aspects of pulmonary tuberculosis and also certain phases of other chronic chest diseases, including those of occupational origin.

Requests for application blanks should be sent to the Wisconsin Anti-Tuberculosis Association, Medical Scholarships Committee, 1018 North Jefferson Street, Milwaukee 2, Wisconsin.

Deadline for returning applications to the committee is February 1, 1951.

Infection Caused By Schistosoma Haematobium*

Report of 2 Cases

By EARL F. CUMMINGS, M. D.
Oshkosh

E. F. CUMMINGS

A diplomate of the American Board of Urology, Doctor Cummings received his M.D. degree from the University of Wisconsin Medical School in 1930. He did postgraduate work in urology at the State of Wisconsin General Hospital and in 1934 entered urologic practice in Oshkosh. During World War II he served for nearly four years with the Army Medical Corps.

WORLD War II is no longer in the headlines, but as physicians we still see the by-products of war affecting the health of patients who have returned from service. It is a historical fact that wars and adventure into foreign lands and climates have always resulted in the spread of diseases into strange and unfamiliar places. Out of Africa, vesical schistosomiasis comes to Wisconsin.

The purpose of this report is to present 2 cases and stress the importance of keeping this disease in mind. The cases exemplify the necessity for taking a thorough history of the patient's geographic travels.

Description of this condition has been somewhat confused by varied terminology: schistosomiasis, bilharziasis, trematodes, hematozoons, worms, flukes, and endemic hematuria. Originally, it was described in 1815 by Bilharz, and it is still commonly referred to as bilharziasis. In its native environment in Africa it is often referred to as endemic hematuria.

For years it was considered very rare in North America, only about 25 cases having been reported up to 1932.

A review of Wisconsin medical literature revealed that no other cases have been previously reported. Undoubtedly, the condition has been diagnosed and the patients treated without formal presentation.

This disease has been well described in previous reports and text books, but it is most important when one is dealing with hematuria and urinary infections, that it must be deliberately sought for and the organism identified in the urine.

Infection by Schistosoma haematobium is primarily African in origin and is especially prevalent in those countries bordering on the Mediterranean Sea. As high as 80 per cent of the native inhabitants of Egypt have been estimated to be infected by the parasite. It is acquired only in those areas where the life cycle of the organism can be fulfilled.

The schistosomas are a genus of flukeworms, and the term Bilharzia is frequently used collectively to denote the three most common types of blood flukes, or trematodes, pathogenic to man. These three species differ in their geographic distribution, their localization in the human body, and their life cycles, as well as in the size and shape of their ova.

1. Schistosoma haematobium lives in the blood stream, mates in the liver, and is responsible for urinary symptoms, as it deposits its ova in the bladder wall. Infection by it is most prevalent in North Africa.

2. Schistosoma mansoni causes many rectal lesions. It is endemic in Africa, the West Indies, and South America.

3. Schistosoma japonicum is noted for producing lung and liver lesions. The condition created by it is largely an oriental disease, prevalent in China, Japan, and the Philippines.

This paper is concerned only with infection by the first species, Schistosoma haematobium.

The life cycle of the trematodes consists of two distinct periods. One is the sexual phase, occurring in the blood stream of the human body; and the other is the asexual phase, occurring in certain types of snails. During the six weeks of life in the snail, the larvae multiply rapidly, develop tails, and are called cercaria. When discharged into the water they swim about looking for a human host, which they enter through the skin, or even the mucous membrane of the mouth. Tingling and redness of the skin may be present when the patient emerges from the infected water or stream. The cercaria lose their tails after penetrating the skin, then pass through the lungs to the liver, where they develop into an adult form, mate, and a new generation commences.

The incubation period in man is normally one to three months, corresponding to the time required from penetration of the skin to the ultimate maturation within the liver. When the parasites reach their full development in the liver, the patient may be sick with chills, fever, general malaise, headache, and gastrointestinal symptoms. The liver and spleen become enlarged and tender, and leukocytosis occurs with an increase in eosinophils.

Upon maturing in the portal system, the parasites swim upstream to the venules and capillaries and become especially prevalent in the vesical, prostatic,

* Read before the Wisconsin Urological Society, May 6, 1950.

uterine, and hemorrhoidal plexuses. Here the ova mature and are deposited in the submucosal tissues, which later rupture into the lumen of the terminal ureter, or bladder, and are again voided. Thus, in those areas especially lacking in toilet facilities and modern sanitation, the ova are able to promptly return to the surface streams and their snail hosts. It is the rupturing of the bladder mucosa, with its attendant venous congestion, which causes the hematuria so characteristic of this disease.

In many patients the first episode of hematuria is transient, and so is ignored, with the result that it goes on to late complications after five or ten years. Hematuria is not always transient but may persist for months or years and result in debility and severe secondary anemia.

The cystoscopic appearance of the bladder lesions is characteristic and varies with the extent and duration of the disease. Early involvement is manifested by an acute diffuse cystitis, with edema and redness about the trigone and bladder base. In this stage, the ova are being deposited in the submucosa. Subsequently, lesions are seen as patchy areas of localized inflammation, which may be pale or necrotic in the center; some of these chronic areas may be covered with crystalline phosphatic deposits, and contain calcified ova within the tissues. This stage hase been picturesquely described as resembling "wet sand shimmering in the moonlight," when seen under the light of the cystoscope.

Less commonly seen are multiple raised, pustular lesions on a red base, which rupture and bleed easily. Due to the severe tissue reaction, hyperplasia occurs, and there may be polyps, inflammatory granulomas and even papillomas present. These granulomatous and papillomatous lesions are laden with ova. Such lesions are often hard to differentiate from papillary carcinoma.

Late complications[1] are common and may consist of vesical fibrosis, pyelonephritis, and hydronephrosis, due to ureteral obstruction. More rarely seen are actual fistulae and abscesses about the penis and scrotum.

Diagnosis is made on the basis of symptoms, identification of the specific ovum in the urinary sediment, cystoscopic examination and possible biopsy of the vesical lesion.

Report of Cases

The first case is that of a Milwaukee man (F.S.) who was seen in military service at Winter General Hospital in 1945. He was 29 years of age and had spent several months in Tunisia during 1942 and 1943. He did not remember drinking any unchlorinated water or eating native food. However, he did go swimming in a swiftly flowing stream, near Gafsa (fig. 1). The camp was in a hot dry climate, with a temperature of 110 F. in the shade. The soldiers had to purify their own water, and they drank very little, because of the unpleasant chlorine

Figure 1

taste. Washing was done in creeks and horse troughs. The patient and his buddies found this particular creek one day while out walking. The stream came from natural springs, and the water was very warm. They noted many white snails about 1 inch in length in the water, as well as in the sand along the banks. His entire unit went in bathing, and he knew of 3 other men who later had hematuria.

When seen, he gave a history of intermittent hematuria first noted 11 months after infestation, and again one year later, in October 1944. The bleeding was never severe nor persistent. He had occasional moderate burning and nocturia during this three year period.

Figure 2

Cystoscopic examination in March 1945 revealed numerous whitish submucosal nodules in the bladder base. One had emptied and was actually bleeding (fig. 2). Typical ova of Schistosoma haematobium were found in the urine. Urograms were normal. Treatment consisted of antimony and potassium tartrate (tartar emetic) given intravenously, in accordance with Army directives.[2] A 5 per cent solution of antimony and potassium tartrate was given intravenously in gradually increasing doses, starting with 4 cc. and increasing 4 cc. daily for six days and then giving 28 cc. on alternate days until a total of 360 cc. of solution had been given. After a week's rest the course was repeated. The patient had distressing chest pains, nausea, and vomiting throughout the course of therapy. Response to treatment was excellent and his bladder lesions subsided; when last heard from in September 1946, the patient was still symptom free.

The second case is that of a 29 year old man (F.F.) from Berlin, seen on December 10, 1949. He was referred for urologic examination because of gross hematuria. For three weeks prior to admission, he had been having backache and for two days he had had burning, frequency, and continuous hematuria.

This patient in 1944 had spent four months in military service in North Africa, being stationed near Port Oran in northern Algeria (fig. 1). He recalled bathing in government-approved streams and small rivers near his camp, as well as in the Mediterranean Sea. The next year was spent in Italy, and he was discharged from the Army, symptom free, in November 1946.

On physical examination he had suprapubic tenderness and his urine was grossly red with blood. Cystoscopic examination revealed a circumscribed area of elevated chronic inflammation in the left bladder base measuring 1.5 cm. in diameter. This area was edematous, with one tiny bleeding point on the surface. The lesion was suggestive of schistosomiasis and, ova were found on microscopic examination of the centrifuged urine (fig. 3). Both ureteral orifices were normal and catheterized without difficulty. Plain film of the kidney, ureter, and bladder area, as well as retrograde pyelograms, were normal throughout both sides. Urine cultures were sterile.

This patient was placed on stibophen (Fuadin) therapy, with dosages of 1.5 cc. the first day, 3.5 cc. the second day, and then 5 cc. intramuscularly on alternate days for 16 doses. After a two week's rest, the course was repeated; considerable nausea, chest and muscle pain were experienced from the Fuadin, but the urinary symptoms subsided promptly.

Summary

Reports are presented of 2 cases of infection by Schistosoma haematobium causing bladder symptoms in patients who were in military service in North Africa.

Figure 3

Diagnoses were made by the cystoscopic appearance of the vesical lesions and by finding the specific ova in the urine. One patient was treated with antimony and potassium tartrate and the other with Fuadin. Fuadin therapy was the better tolerated of the two, and both drugs are considered specific for infection by Schistosoma haematobium. With either drug, the relapse rate is high and follow-up care for five to ten years is indicated.

Conclusions

Schistosomiasis does occur in Wisconsin and must be carefully sought for in cases of hematuria and chronic cystitis, especially in those people giving a history of having lived in areas of the world where this disease is endemic.

2. Treatment with antimony and potassium tartrate (tartar emetic) and Fuadin are rapidly effective in killing the parasite and its ova.

3. Unless completely eradicated in the early stages, serious, late manifestations of the disease may occur even 10 to 15 years later.

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Intussusception in a Four Month Old Infant

Report of a Case

By WILLIAM B. A. J. BAUER, M. D.
Ladysmith

W. B. A. J. BAUER

Doctor Bauer was graduated from the Long Island College of Medicine in 1939. Following six months as a house officer in Brooklyn State Hospital, he served an eighteen month internship at Minneapolis General Hospital. Since that time he has been practicing medicine and surgery in Ladysmith. He is a fellow of the American College of Physicians.

THIS case is reported for two reasons: first, because the more significant symptoms in intussusception were absent; and, second, because the method of surgical treatment was unusual.

A white male child was born on Sept. 22, 1943. There was no history of injury or illness until the day of admission to the hospital, Jan. 22, 1944, at which time the mother reported that her breast-fed infant was suffering from periodic bouts of "colic" of sudden onset. The severe colicky pain was followed by emesis. There had been two small, semisolid bowel movements on that day, but no mucohemorrhagic material was passed. The most significant symptoms suggestive of obstruction to me were the periodicity of the colicky pains and the periodic rumbling abdominal noise, which the mother reported.

Examination revealed a well developed 4 month old infant in no acute distress. There were no signs of respiratory infection, although the temperature was 102 F., pulse rate 120, and respiratory rate 40 per minute. The abdomen was soft; no mass was palpable. Rectal examination proved valueless. There was no stain on the diaper. During two hours of observation no periodic colicky pains or borborygmus was noted.

An x-ray of the abdomen showed no abnormalities. The urine contained a trace of albumin, 2 plus mucus, and occasional white blood cells. The white blood cell count was 10,200, with 16 per cent stab cells, 26 per cent segmented neutrophils, and 56 per cent lymphocytes. Once during the night loud rumbling abdominal noises of short duration were heard by the mother.

The following morning, January 23, the child vomited at the end of its feeding practically the entire amount taken in. The white cell count at this time was 7,500, with 9 per cent segmented neutrophils, 26 per cent stab cells, 62 per cent lymphocytes, 2 per cent monocytes, and 1 per cent basophils. Although the child continued to vomit its feedings during the day, he remained alert and free from distress and had no outward signs of dehydration. The temperature rose to 102.8 F., pulse rate remained at 120, and respiratory rate at 40. Physiologic saline and Hartman's solution were given parenterally.

That evening the white cell count, differential count, pulse rate, and respiratory rate were the same as they had been in the morning, but the temperature had dropped to 100 F.

Early in the morning of January 24, I heard distinct borborygmi without a stethoscope. The child did not vomit. Palpation of the abdomen revealed some resistence on the right and a definite mass. A count at this time revealed 11,600 white blood cells, with 10 per cent segmented cells, 30 per cent stabs, and 4 per cent juveniles, 32 per cent lymphocytes and 2 per cent monocytes.

Surgical treatment was undertaken at once. Open drop ether was used. A lower right rectus incision was made, exposing the peritoneal cavity, through which a profuse clear fluid emanated. Both the small and the large bowel were distended, particularly the cecum and the distal ileum and the ascending colon. No exploration was necessary to identify the mass in the cecum, the latter being markedly distended and indurated. It was apparent that the ileum was the intussusception and that the intussuscipiens was the cecum. Manipulation of expressing and coaxing was in vain. I fear that I did not completely follow the admonition of Hamilton Bailey, who says, "push but never pull," but even my gentle pulling proved fruitless. In any event, a "door" was made in the anterior wall of the cecum, which had been delivered and packed off from the rest of the abdominal cavity. The "door" was 2.5 cm. in the long axis of the cecum, with a transverse width of 2 cm. Through this aperture the intussusceptum was extracted. It was interesting here to note that the ileum had telescoped seven times within itself. At its base, the ileocecal valve, edema, and many thicknesses of tissue had completely closed the lumen. Attempts to release one layer from the other were unsuccessful, due to adhesions between layers. It was also interesting to note that the distal limb of the intussusceptum had formed a cystic knob.

The whole gangrenous mass was extracted through the door in the cecum. The cecum and ileum were turned to expose their posterior surface. Interrupted triple 000 chromic sutures were placed about the periphery of the ileum at its junction with the

cecum. These sutures went through the serosa and muscularis of the cecum and then through the same layers of the distal ileum just proximal to the intussusception. The intussusceptum was then cut away at the ileocecal valve through the "door" in the cecum. The "door" in the cecum was closed with through and through interrupted triple 000 chromic sutures. This was reenforced with a small omental graft. The appendix was then removed because it interfered with a second row of interrupted serosal sutures, about the periphery of the new ileocecal junction. The wound was then closed in layers.

At the conclusion of the operation, the pulse rate was 140, the temperature was 102.8 F., and the respiratory rate was 46.

That evening the temperature climbed to 104 F., but the pulse rate was down to 120 and the respiratory rate to 40. The child ran a relatively usual postoperative course and was discharged on January 30 in satisfactory condition. He has been well since.

Comment

There are several unusual features in this report of a case. First is the relative paucity of symptoms and the importance of the mother's observation about the pain and borborygmi. Secondly, the method of resection used in this case was different from Jessett's operation in that no mucosal sutures were placed at the ileocecal junction. Thus, these sutures were placed outside and none within. Mortality following resection is extremely high in infants, particularly with intestinal anastomosis (80 per cent). It, therefore, seemed wiser to use this method as representing minimal operation for this particular infant rather than perform an anastomosis of ileum to transverse colon.

While I am sure that Hamilton Bailey is correct in avoiding general anesthesia, my experience with spinal in infants is so limited that I did not feel warranted in using it.

Summary

A case of ileocecal intussusception occurring in a 4 month old infant is reported. In spite of a 15 cm. gangrenous ileal intussuscipiens, which was resected, diagnostic symptoms were meager.

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UNIVERSITY MEDICAL SCHOOL TO PRESENT INTENSIVE COURSE ON CORTISONE AND ACTH

An intensive one day course on Cortisone and ACTH will be presented by the University of Wisconsin Medical School on January 17. The course has been organized and will be supervised by Edgar S. Gordon, M. D., associate professor of medicine, who is in charge of the clinical research being done in this field. Instructors will include Doctor Gordon, S. B. Crepea, M. D., assistant professor of medicine; and Roland K. Meyer, Ph. D., professor of zoology.

It is planned that each of the presentations will be illustrated by the use of patients in the form of a "wet" clinic. Two medical films, "The Physiologic Basis for the Action of ACTH in Human Beings," and "The Therapeutic Use of ACTH in Human Disease," will be presented through the courtesy of the Armour Company.

Advance registration is required and may be made by writing to Dr. Robert C. Parkin, Coordinator of Graduate Medical Education, 418 North Randall Avenue, Madison 6, Wisconsin. The fee is $3.00. Formal registration will be held in classroom 3 of Temporary Building T–14, which is located at the rear of the Nurses Dormitory, at 8:30 a. m. on the day of the presentation.

Present Day Treatment of Gonorrhea*

By PAUL C. GATTERDAM, B. S., M. D.
La Crosse

P. C. GATTERDAM

Doctor Gatterdam received his medical degree from Washington University School of Medicine, St. Louis, following his graduation from the University of Wisconsin with a bachelor of science degree. Since 1924 he has been on the staff of the Gundersen Clinic, La Crosse, and La Crosse Lutheran Hospital. He served with the United States Army during World War I and also participated in the Mexican Border Campaign in 1916.

THE treatment of gonorrhea prior to 1938 was usually long, discouraging at times, and associated with numerous untoward complications and sequelae. Even under the best of medical regimen, epididymitis, prostatitis, and other complications in the male were common; and in the female frequently the first symptoms were those of salpingitis and pelvic abscess. This required long tedious hospital treatment, frequently resulting in sterility.

Since the use of the sulfonamides and, later, penicillin, the treatment of gonorrhea has been simplified. Many physicians trained after 1938 are not aware of the numerous and disabling complications, with the result that there is now a tendency to consider gonorrhea a minor infection. This is not true, and it is cause for considerable concern. It is true that, with present day therapy, in many cases gonorrhea does respond much more quickly to treatment than a "common cold," and cures are many times more rapid; however, one must not lose sight of the fact that complications and sequelae still do occur with chemotherapy; that the gonococcus is capable of suddenly acquiring virulence; and that not all patients are cured with one course of treatment.

It is not the purpose of this article to go into the history, the cultural, or the sociologic aspects of the disease, or its epidemiology. It is merely an outline, for the general practitioner, of the treatment methods that are considered satisfactory and reliable at the present time.

The medical journals are filled with reports on the use of streptomycin, dihydrostreptomycin, Aureomycin, Terramycin, and oral penicillin. They all may have a place in treatment of gonorrhea, but their value has not been established definitely as yet. However, they are indicated in patients who do not respond to penicillin. Therefore, this article will be limited to the treatment with penicillin alone, and to the necessary follow-up and after care.

Every case of urethral discharge in the male should be studied with direct smears and cultures when indicated. To attribute a chronic or an acute urethral discharge to the gonococcus without the demonstration of the organism is an untenable presumption. In the female, direct smears and cultures should be obtained from the urethra, the cervix, the rectum, and the vagina prior to the use of any type therapy. One negative report should not be accepted as final but should be repeated.

The percentage of positive smears and cultures can be increased by the removal of the mucous plug and massage of the cervix.

Treatment

Once a definite diagnosis of gonorrhea has been established, the treatment consists of the administration of 600,000 units of penicillin in a single dose or in two divided doses intramuscularly. Many feel that a single dose of 300,000 units is sufficient in the majority of cases, but in view of the low cost of penicillin at the present time, as well as other factors to be considered later, it is advantageous to give two doses of 300,000 units each within a period of 24 hours. While any form of penicillin may be used, the one suggested is that of penicillin in oil with aluminum monostearate. Many authorities prefer to give the old type aqueous penicillin in four doses at two hour intervals of 100,000 units each. The patient should be cautioned during treatment to avoid alcoholic drinks of any type and any form of erotism, as both have a definitely deleterious effect upon the disease.

After the administration of penicillin as outlined above, a high percentage of patients will be cured (approximately 90 per cent). However, from then on, the follow-up is very important, so that the 5 to 10 per cent of patients who are not cured by this treatment are not neglected. Otherwise, chronic gonorrhea may develop, with all its severe complications, or the patients may become carriers of the disease.

If a physician has not sufficient time to follow up these patients and to carry out the time-consuming examinations to establish a cure, then he should refer his patients to someone who has the time and inclination.

Should the treatment with 600,000 units as prescribed not effect a cure in a particular patient, penicillin therapy should be repeated. If, following a second course, the organisms are still present, other forms of chemotherapy should be used. We

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* Prepared for the Committee on Venereal Diseases of the State Medical Society of Wisconsin.

suggest Aureomycin in doses of 500 mg. every six hours for three or four days. Should Aureomycin also be ineffective, then sulfonamides should be tried.

The question arises sometimes as to the administration of penicillin in cases in which a gonorrheal infection has developed but in which syphilis may also be developing at the same time. As the incubation period of syphilis is longer, naturally the appearance of the chancre, secondary rash, and positive serology comes considerably later than the urethral discharge of gonorrhea. Gonorrhea usually develops in 48 to 72 hours after exposure, and, as penicillin is apparently specific for syphilis, as mentioned in the previous article in the *Journal*, it is highly possible that in gonorrhea cases doses of penicillin larger than the 300,000 units are definitely advantageous. However, as syphilis may become evident later, having been contracted at the same time as the gonorrhea, the patient must be advised to have a Wassermann test taken at monthly intervals for three months and then a follow-up later on.

Criteria for Cure

Criteria for cure in the male are the disappearance of clinical signs and symptoms followed by three negative urethral smears at weekly intervals. Prostatic smears and cultures may be necessary in complicated cases. In the female also, cervical smears and cultures should be taken at weekly intervals.

A most important factor in the eventual eradication of gonorrhea is the reporting of all cases to the State Board of Health, as required by law. One should also report sources of infection to local health authorities. While our first duty is to treat the patient with gonorrhea, it is just as important to search for the source of this infection, so that this partner, too, may have the opportunity of treatment and will not continue to infect new persons. Many physicians do not feel that it is their duty to question the patient as to the source of the infection. But this must be done if eradication of gonorrhea is to be accomplished. No physician is unwilling to report cases of other communicable diseases, particularly as to the source of infection and possible contacts, and this is a very infectious disease in which the source of contact is usually fairly easy to establish. Local health offices and officers are always willing to cooperate and if a source of infection is reported, they will see that the patient comes under the treatment of the physician of his choice.

I would like to emphasize again that it is very important that every effort be made to locate and report the source of the infection, so that some day venereal diseases may become a thing of the past. This is perhaps too optimistic, but, nevertheless, every effort should be made to approach this final goal.

Present Day Treatment of Chancroid, Lymphogranuloma Venereum, and Granuloma Inguinale*

By RICHARD J. ROWE, M. D.

Marshfield

R. J. ROWE

Doctor Rowe, a graduate of the University of Wisconsin Medical School, received his training in dermatology and syphilology in the Department of Dermatology and Syphilology of the University of Michigan at Ann Arbor. While at the University of Michigan he received a master's degree in dermatology and spent part time working on experimental syphilis. He is now a dermatologist at the Marshfield Clinic and St. Joseph's Hospital, Marshfield, Wisconsin.

SINCE World War II chancroid, lymphogranuloma venereum, and granuloma inguinale have become more widely disseminated, and, though rare, they are likely to be encountered in any practice.† Along with this dissemination, methods of treatment have improved considerably.

The diagnosis of these diseases is at times a difficult problem, often requiring a variety of laboratory procedures and the best available assistance. Venereal diseases often occur together, and great care must be taken not to overlook syphilis which may accompany any of the other venereal diseases

* Prepared for the Committee on Venereal Diseases of the State Medical Society of Wisconsin.

† A more complete clinical description of these diseases[1], with illustrations, will be found in the United States Public Health Service supplement No. 19 to venereal disease information. This pamphlet may be bought for 15 cents from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C.

or be mistaken for them. The examination of any genital lesion is not complete without a darkfield examination of fluid from the lesion for spirochetes and a serologic test for syphilis. This serologic test should be repeated at six weeks, three months, and perhaps even later, depending on the character of the patient and the type of treatment given.

Chancroid

Chancroid is a disease usually spread by sexual intercourse and is probably slightly more prevalent than syphilis in the United States as a whole. It is caused by Hemophilus ducreyi, a gram-negative bacillus. The incubation period is usually from about three to five days. The lesion begins as a vesicopustule and soon develops into a tender ulcer which has a necrotic, non-indurated, purulent base. The ulcers may have a ragged, undermined edge. They may be single or multiple and are accompanied in more than half of the cases by inguinal adenitis. This bubo is usually unilateral, inflamed, and painful.

Even though clinically many of the attributes of chancroid are in contrast to the chancre of syphilis, darkfield examination and serologic tests should be done to rule out syphilis.

The diagnosis is suggested by the painful ulcer which usually is not hard and infiltrated as the primary lesion in syphilis. It can be established definitely only by demonstration of the causative organisms in smears obtained from the ulcer. For this purpose a piece of tissue can be removed with a curette, squeezed between two glass slides, and then stained properly. Smears prepared from the pus of the ulcer usually do not show the organism. Skin tests performed with a vaccine of Hemophilus ducreyi are helpful, but false positive reactions do occur. Furthermore, particularly in the early stages of the disease, the skin test may be negative in the presence of chancroidal infection.

Treatment

Chancroid responds well to treatment with sulfonamides. Sulfathiazole is the drug of choice. One-half to 1 Gm. should be given four times a day for seven days. This course may have to be repeated, depending on the response of the individual patient.

Penicillin is of questionable value in the treatment of chancroid; streptomycin does not seem to be as good as the sulfonamides.[3] Therapy with the newer antibiotics is still in the experimental stage. Apparently 5 to 10 Gm. or more of Aureomycin or Chloromycetin given during at least a five day period is effective therapy.[2,4,5] In the present state of affairs, Aureomycin and Chloromycetin probably should be reserved for those patients that either do not respond or are sensitive to sulfathiazole.

Fluctuant buboes should be aspirated but not incised.

Granuloma Inguinale

Granuloma inguinale is a disease which has been known by a number of different names: Donovanosis, Donovaniasis, ulcerating granuloma of the pudenda, granuloma venereum, granuloma inguinale tropicum, ulceration of the groin, and others. Even though it may not be the best term,[11] granuloma inguinale, because of common usage, is probably the term of choice. This disease is a granulomatous process which usually occupies the inguinal region.

The Donovan body is generally considered to be the etiologic agent. This Donovan body (Donovania granulomatis) has been cultivated on fresh yolk media,[6] and so far has not proved infectious when inoculated into human beings. However, if fresh tissue containing Donovan bodies is inoculated into a human being, infection may result.[7]

The incubation period of this disease is reported to vary from two days to three months. The venereal origin of granuloma inguinale is not as evident as in other diseases reported in this series. The disease is most common in the Negro race and occurs most often in the 20 to 40 age group.

The lesion starts as a vesicle, papule, or nodule. This develops into an ulcer that is usually clean and not painful and has a granular base which bleeds easily. The lesions have little tendency to heal. Daughter lesions frequently occur near the edge of the developing lesion and coalesce to form a more extensive process. The advancing border of the lesion has rolled edges; the granulation tissue tends to pile over onto the normal epithelium. Secondary hypertrophy of the external genitalia may occur.

Buboes are not as frequent in granuloma inguinale as in chancroid and lymphogranuloma venereum. Extragenital lesions may occur.

The clinical diagnosis should always be confirmed by demonstrating the Donovan body in tissue spreads. For this purpose a clean piece of granulation tissue should be crushed between two glass slides and stained with Wright's stain.[12] Skin tests and complement-fixation tests are still of limited usefulness.[8, 9]

Treatment

The drug of choice at present is streptomycin. A total of 20 Gm. given over a period of five days is usually effective.[2] Aureomycin and Chloromycetin are also effective therapeutically. Evidently the dosage should be between 20 and 40 Gm. given over a period of at least ten days.[2, 4] In any case in which the patient does not respond readily to therapy, a biopsy should be done to rule out carcinoma.[10]

Lymphogranuloma Venereum

Lymphogranuloma venereum is another disease which has been known by a number of different names, among which are lymphopathia venereum, lymphogranulomatosis inguinalis, Nicolas – Favre

disease, and climatic or tropical bubo. It is a virus disease which is acquired by sexual intercourse. The disease occurs most often in the Negro race and again in the 20 to 40 age group. It is not a rare disease in the lower strata of society.[14] The incubation period is probably about 7 to 12 days in most cases.

The primary lesion, rarely observed, is an evanescent erosion located in the external genital area. About two weeks after the appearance of the primary lesion, the inguinal lymph nodes enlarge. Constitutional signs and symptoms commonly accompany the enlargement of the nodes. In the early stages these nodes are discrete, movable, and tender. As the infection progresses, periadenitis develops, the nodes may soften, and multiple fistulous tracts sometimes occur. The inguinal adenopathy is unilateral in two-thirds of the cases. The disease may progress to considerable scarring and enlargement of the external genitalia. The disease may follow the lymphatic drainage to the anal and rectal area. Extensive involvement and eventual destruction of the perineal area may result. Inflammation around the rectum often results in rectal strictures which frequently are the only manifestations of lymphogranuloma venereum. Diagnosis and treatment of these strictures are surgical problems sometimes requiring considerable study and skill.[13]

The skin test, the so-called Frei test, and complement-fixation reactions are well recognized diagnostic procedures in this disease.[14] However, once the skin test has become positive, it usually remains positive for life. Therefore, a positive Frei test does not mean active lymphogranuloma venereum. Again laboratory tests should be done to rule out syphilis.

Treatment

Lymphogranuloma venereum does not respond to either penicillin or streptomycin. Sulfathiazole in a dosage of 4 Gm. initially and 1 Gm. every four to six hours thereafter to total 40 Gm. has given good results. Aureomycin, according to Robinson, is probably the treatment of choice in this disease.[2] However, the dosage used so far varies widely. Greenblatt, and associates[4] found it necessary to give 75 to 100 Gm. in 37 to 60 days in some cases, before marked improvement was noted. Relapses have occurred after dosages of 40 to 100 Gm. of Chloromycetin, but this drug may be of value in patients who cannot take Aureomycin.[4] Aspiration and drainage of suppurating lymph nodes is often indicated, but, as a rule, excision of these nodes should not be undertaken because elephantiasis of the external genitalia and legs may follow.

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Current Concepts of Cirrhosis*

By J. L. SIMS, M. D.
Madison

J. L. SIMS

Doctor Sims, a graduate of the University of Texas Medical School, spent four years with the Army Medical Corps following internship and four years of residency, three of them at the State of Wisconsin General Hospital. In 1946 he returned to the University of Wisconsin, where he is now an assistant professor of medicine. He is a diplomate of the American Board of Internal Medicine.

A CONSTANTLY increasing flood of clinical and experimental observations has produced steady evolution in our concepts of cirrhosis in the past 10 to 15 years. Much of what has been reported has seemed conflicting and confusing, but principles have developed which must give direction to any clinical consideration of hepatic disease.

Classification

Controversies as to what constitutes cirrhosis and its proper classification have been numerous. Conveniently, the changes in clinical definition relate primarily to etiology and pathogenesis. Any practical morphologic classification would still appear reasonably familiar to physicians of an earlier generation (table 1).

TABLE 1.—*A Classification of Cirrhosis; Modified from A. J. Patek Jr.*[1]

1. Portal cirrhosis
   (a) Laennec's (atrophic) cirrhosis
   (b) Pigmentary cirrhosis (hemochromatosis)
   (c) Cirrhosis of hepatolenticular degeneration, or Wilson's disease
2. Biliary cirrhosis
   (a) Obstructive
   (b) Cholangitic
   (c) Cholangiolitic
   (d) Xanthomatous
3. Coarsely nodular cirrhosis (postnecrotic scarring)
4. Cardiac cirrhosis
5. Syphilitic cirrhosis
6. Zooparasitic cirrhosis

Some of the forms require only passing mention. The zooparasitic type, extremely rare in this area, represents an inflammatory and fibrotic reaction to certain parasites or their ova. In Wilson's disease, also quite rare, an unknown congenital factor results in histologically typical portal cirrhosis which is often overshadowed by neurologic manifestations. Cardiac cirrhosis, if one accepts it as cirrhosis, and many do not, is a result of prolonged passive congestion. Parenchymal atrophy with secondary fibrosis develops about the central veins, but at times may also involve peripheral areas to simulate a portal lesion. Hemochromatosis, from the hepatic standpoint, represents a fairly typical portal cirrhosis associated with extensive deposit of pigments related to hemoglobin. It is probably due to a disorder of iron metabolism.

Postnecrotic scarring is a result of one or more isolated instances of irregular massive necrosis, for which infection, toxins, or other factors may be responsible. In areas of complete parenchymal destruction the mesenchymal framework collapses and is transformed into heavy bands of fibrous tissue. Surviving parenchyma undergoes compensatory and restorative hyperplasia to form nodules between these scars, and some proliferation of bile ducts may be seen. Once developed, the condition is theoretically static, although mechanical interference with vascular and biliary channels may occasionally cause difficulty.

Biliary Cirrhosis

Despite many unsolved problems of etiology and pathogenesis, obstructive biliary cirrhosis presents a fairly clearcut clinical problem. Extrahepatic obstruction is followed by dilatation of the larger ducts and plugging of the smaller ones with inspissated bile, cellular infiltration of the portal areas, parenchymal damage, and, finally, extension of fibrous tissue from the portal areas to invade and surround the lobules. Prolonged partial obstruction may be at least as damaging as a more acute complete blockage. Some workers feel that cholangitis without obstruction may have a similar result (cholangitic biliary cirrhosis). Splenomegaly as a rule is not marked, and ascites and hematemesis are unusual late manifestations. The primary need is for early and accurate diagnosis, for, in the absence of severe persistent cholangitis, there is a strong tendency to restoration of normal structure after relief of the obstruction. Xanthomatous cirrhosis may closely resemble that due to biliary obstruction, modified by the presence of large numbers of lipid-laden cells, and conditions so diagnosed clinically not uncommonly prove to be due to unrecognized obstruction.

Postal Cirrhosis

Of greater importance are the remaining groups of portal and cholangiolitic cirrhosis. The former, in spite of its several probable causes and variable behavior, must for the present be considered a sin-

* Presented before the One Hundred and Eighth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1949.

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gle entity. It has never been possible to attach real significance to its morphologic variations except as they indicate the stage and degree of activity of the process. Indeed, Chaikoff[2] found widely differing anatomic changes in a group of experimental animals exposed to presumably identical cirrhosis-producing diets.

It should be noted that in certain cases true cirrhosis may remain in a "latent" or "compensated" state for many years. This may occur as a result of treatment, or such conditions may be discovered in the course of operation, examinations for other reasons, or at autopsy. Except in the last instance, such discovery always raises the question of need for treatment or restriction of activity. Careful study by biopsy, function tests, history, and x-ray is required, since evidence of activity or functional insufficiency may be present in any one of these areas alone. Quite probably none of these is truly inactive, but the minimal manifestations and rate of progression may demand no therapy except avoidance of toxins, excesses, or deficiencies which might cause exacerbation.

In spite of their similar anatomic features, portal cirrhoses of differing origin seem to vary in their response to treatment, and investigation relative to background is valuable. In this country, 50 to 70 per cent of cirrhotic patients will have a history of alcoholic excess. Various studies record an antecedent jaundice of presumably etiologic significance in another 5 to 17 per cent. Among the remainder, some may have had a non-icteric infectious hepatitis, but a number of other causes may also be operative.

Dietary Factors

In the late thirties, Connor[3] and Patek[4] focused attention on the role of fatty metamorphosis and diet in alcoholic cirrhosis. Concurrently, many other studies demonstrated that cirrhosis can be produced in animals by nutritional abnormalities. Such reports related chiefly to over-all decrease in dietary protein, increased lipid intake, and deficiency of certain specific protective or lipotropic factors. With deficiency of protein, and specifically of cystine, necrosis has been described. Excessive fat intake or lack of choline to assist in its removal from the hepatic cell results in fatty metamorphosis. Methionine experimentally seems to protect against both these reactions. Himsworth[5] has postulated that the liver cells, swollen by fat, obstruct the sinusoidal blood flow, causing parenchymal degeneration and death, while stimulating fibrous tissue proliferation. Whether or not this is the mechanism, such changes follow dietary injury. Young fibrous tissue, highly vascular and heavily infiltrated by inflammatory cells, begins to proliferate both from portal areas and to some extent from about central veins. Degenerated parenchymal cells may be replaced by multiplication of surviving cells in the same lobules, while compensatory hyperplasia of other areas also occurs. Such regenerating cell masses often may not connect properly with the portal vein, getting much of their blood supply instead from arterial radicles in the fibrous tissue. Asymmeteric cellular proliferation may displace central veins toward the periphery of the lobules, and the fibrous tissue about portal and central vessels may unite into single bands, at times including direct vascular communication between the two. The parenchyma then appears as poorly organized cell masses, lying between bands of fibrous tissue, and often stained by bile pigment because of inadequate connection with bile ducts. So disorganized, and with an abnormal blood supply perhaps poor in the nutrient and protective factors normally abundant in the portal flow, the cells are rendered increasingly susceptible to further injury. Thus, in time, the process becomes almost self-perpetuating, with massive distortion and remodeling of the normal structure, the process to which the resounding name of "Umbau" has been applied by German pathologists. Strong support for an identical pathogenesis in human cases, in which serial biopsies are not usually feasible, is found in the frequent reproduction of each of the stages in those tissues which do become available.

Other than proof of the fact that nutritional factors can and do produce cirrhosis, probably the most significant finding in such studies is that in the fatty or even the early fibrotic period, correction of the causative condition results in a complete resolution of the process, and in the intermediate phases a certain degree of arrest can be obtained. As the remodeling, or "Umbau," continues, increasing susceptibility to injury renders the process more or less self-perpetuating, and the most that can be expected is avoidance of acceleration of the damage and some symptomatic relief. Patek, from the clinical standpoint, has emphasized that the earlier the diagnosis, the better the results of therapy. Such emphasis is particularly appropriate in the so-called "alcoholic fatty liver," in cases of which both Connor and Dock[6] have found that patients with a clinical picture simulating advanced disease, manifested by ascites, jaundice, or hematemesis, may actually have only extreme fatty involvement, with minimal or no fibrosis. Interestingly, Dock has also shown that the resistance to perfusion of blood through such fatty livers may exceed that in advanced portal cirrhosis.

For some years prior to these observations, high carbohydrate, low protein diets had been recommended for cirrhotic patients, based on such reports as those showing a protective effect of carbohydrate against chemical toxins and the precipitation by lean meat of ascites and death in Eck fistula dogs. Opinion then shifted, and the patient was overwhelmed with protein, while his already poor appetite was further discouraged by meals made unattractive by drastic fat restriction. Not only were such diets difficult to plan, but patients often simply could not eat them, thus defeating their purpose. It was gradually realized that in the absence of specific lipotropic factor deficiency, extremely high fat rations were required to produce hepatic injury. Clinicians,

meanwhile, were finding no ill effects from moderate fat intakes, and the continuing successes of Patek[7] with what he termed simply a highly nutritious diet were being amply confirmed by others. A diet such as this, which emphasizes meat, fish, poultry, eggs, fruit, and green vegetables, and provides some 3,500 calories daily, divided roughly as 350 Gm. of carbohydrate, 140 Gm. of protein, and 170 Gm. of fat, is now widely employed. As pointed out by Ratnoff,[8] we thus complete a cycle back to the "milk, eggs, farinaceous substances, and plainly cooked fish and meat" advised by Murchison in his text on liver disease published in 1868.

On the basis of the same animal experiments there has been a good deal of advocacy of choline and methionine dietary supplements. Confirmation of their value in human cirrhosis has not been easy to obtain. Some workers have found no benefit at all, and point out that an adequate diet contains considerable quantities of these materials. Others, on similar diets, have found histologic and functional improvement only in those patients receiving such supplements. So far as is known, methionine has no harmful effect, and since it experimentally both protects against the necrotizing effect of protein deficiency and provides lipotropic activity through its labile methyl group, its use seems justifiable and probably desirable until definitive data are forthcoming. Doses of 4 to 6 Gm. per day are generally employed.

The same cannot be said for some of the other individual dietary factors which have been recommended. Cystine, for example, which under controlled circumstances protects against the necrosis of protein deficiency, has in other experiments caused fatty infiltration by utilizing the available methionine for protein synthesis. Similarly, work by Ralli and Rubin[9] suggests that inositol, which protects against certain types of fatty cirrhosis in rats, and has been widely advertised for use in human cirrhosis, may under certain experimental conditions greatly increase fatty infiltration. Even so presumably innocuous a substance as nicotinamide may under proper conditions disturb a balanced dietary deficiency and permit development of a fatty cirrhosis. Generally, then, excesses of so-called specific factors are to be avoided until their safety and value are established, and reliance placed on naturally balanced foodstuffs. Where adequate intake is questionable, supplementation of the diet by a single multivitamin capsule and a small dose of a crude B complex preparation would seem proper, however.

Not only must the diet be adequate, but it must be eaten to be effective. Great effort is sometimes necessary to get these patients to eat. It helps to take time to explain to the patient that therapy is of necessity a long term project in cirrhosis and that intake of adequate amounts of food is of extreme importance. Tube feeding and parenteral infusions may be helpful for brief periods, but cannot be relied upon for long term management. One point frequently overlooked in this connection is the influence of ascites. Ascites and intestinal edema greatly impair both appetite and gastrointestinal function. All too often the only concession to ascites is the performance of paracentesis and partial removal of fluid when pressure becomes too distressing. Actually, all the measures used in cardiac edema (except digitalization) are applicable. Very low sodium diets, acidifying salts, and mercurial diuretics, intelligently used, often give very encouraging results. If paracenteses are necessary, they should be performed for smaller fluid accumulations, and removal should be as complete as possible. It is here, too, (along with their role in preventing hematemesis) that the recently popular portocaval shunts have their place. Paradoxically, it is the marked impairment of hepatic circulation which permits the procedure. Sudden interruption of a normal portal flow usually has disastrous results, but in advanced cirrhosis, in which a major portion of the hepatic blood supply is arterial, the only effect of the new surgical connection is to divert the portal blood from inadequate portocaval anastomoses to an efficient communication. The resultant lessening of portal hypertension and hence of the tendency to ascites and hemorrhage cannot be expected to benefit the liver directly, but it may offer a great deal of indirect help in that the relief of ascites and intestinal edema may greatly improve appetite and food absorption.

Post-Hepatitic Cirrhosis

Patients with a history of alcoholism are the ones who seem to benefit most from such dietary schedules. Results are not nearly so good in other cases. Hence, careful consideration of etiology is important in planning treatment. It is increasingly evident that in a certain number of cases cirrhosis is due to chronic inflammatory and degenerative reactions following infectious hepatitis. This was seriously questioned for a time, but continued observations, including serial biopsies, seem to offer conclusive proof. Nonfatal acute hepatitis may take varying courses. Complete recovery with restoration of normal architecture is the rule.[10] In a very few, necrosis is of such degree that, although the patient recovers promptly, postnecrotic scarring remains. Somewhat more commonly a chronic hepatitis develops. Inflammatory cell infiltration of the portal areas (Lichtman's chronic portal hepatitis) is perhaps the most typical anatomic change, but in some cases it takes other forms, and in even more the hepatic parenchyma may appear rather normal in spite of other signs of activity. Eventually, healing without apparent residua is usual, but in a few patients there is progression to cirrhosis.

Some of these are of the usual Laennec's or atrophic portal type. Others, either initially or as they progress, take the form of so-called cholangiolitic hepatitis. This picture, known for some time, was reemphasized a few years ago by Watson and Hoffbauer.[11] It may closely simulate, in its acute phases, an obstructive jaundice, with pruritus,

acholic stools, elevated phosphatase, and normal parenchymal function tests. The anatomic lesion in the early stages is not at all well established, but presumably relates to damage to the cholangioles, small canals between the bile canaliculi and the true bile ducts. Its progress to cirrhosis is marked by diffuse invasion of fibrous tissue into the lobule and between the cell cords, bile plugging of the canaliculi, and often considerable enlargement of the liver. The advanced phases closely resemble the picture described by Hanot as hypertrophic biliary cirrhosis.

The essence of treatment of acute and chronic viral hepatitis is complete and prolonged bed rest. It must be emphasized, however, that such a prescription carries with it an inherent responsibility that an early and accurate diagnosis be made. The possible ill effects of surgical intervention in active hepatitis are well known. Almost as undesirable, however, is delay in relief of true biliary obstruction, or a long period of enforced inactivity because of misdiagnosis of other conditions as a result of the present highly commendable interest in chronic hepatitis. Unrecognized hemolytic tendencies, familial nonhemolytic icterus, sarcoidosis, brucellosis, and psychoneuroses are among the conditions for which such instances might be cited.

The value of biopsy as an early diagnostic procedure deserves stress. It is especially helpful in differentiating chronic hepatitis of the cholangiolitic type from partial or intermittent obstruction. It is also of very considerable help in permitting early and definitive treatment in those not infrequent cases of severe fatty change or even well developed cirrohis which show normal function tests.

Mention should be made of bed rest as an adjunct in management of the more active phases of portal cirrhosis. Reasons for its value are not clear. Bradley[12] has demonstrated that there is a considerable reduction in hepatic blood flow in the upright as compared to the recumbent position, and, of course, rest decreases the metabolic load, but it is probable that these are only two of several factors. Whatever the reason, it has been repeatedly noted that these patients do better when put at rest, and Klatskin and Yesner[13] have found that patients with alcoholic cirrhosis who are kept in bed, with withdrawal of alcohol, show improvement even though on a very minimal dietary intake.

Alcohol and Drugs

It is increasingly popular to deprecate the effect of alcohol and emphasize nutrition in so-called alcoholic cirrhosis. It is true that no one has ever proved that alcohol per se can cause cirrhosis or that moderate amounts are harmful if dietary balance is not disturbed. There is reason, however, to believe both from animal experiments and from clinical observation that alcohol can potentiate the action of other detrimental agents. Too, the person so severely alcoholic as to have a cirrhosis develop on a nutritional basis is not apt to be temperate if permitted access to it, and diet will suffer. Hence, it would seem that alcohol is best forbidden entirely.

Some care is necessary, too, in the use of drugs. Many agents depend on the liver foı detoxification, and cirrhotic patients may be extremely sensitive to their effects. Such a situation is well recognized in regard to barbiturates, morphine, and anesthetic agents, of course, while its importance in relation to sex hormones is suggested by the tendency to gynecomastia and testicular atrophy. In unavoidable surgical procedures, great care should be taken to provide a high oxygen concentration in the anesthetic mixture and to insure that a free airway makes possible its utilization.

In conclusion, this review has touched only on those points which have already found direct clinical application. The mass of studies which have not received such emphasis dwarfs this relatively limited group, and gives promise of many more far reaching advances in the near future.

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The Wolff-Parkinson-White Syndrome

Report of a Case Illustrating Also the Post-Tachycardia Syndrome

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THIS is a report of a case of the Wolff–Parkinson–White[1] syndrome in a patient who also had the post-tachycardia syndrome following an episode of paroxysmal tachycardia. The report of the case will be preceded by a review of the literature.

Definition

The Wolff–Parkinson–White syndrome has an electrocardiographic pattern of short P–R interval and prolonged QRS complex. It is found mostly in young persons; organic heart disease is absent; patients have a tendency toward paroxysmal tachycardia. It is believed due to a congenital anomaly, an accessory conduction pathway between auricle and ventricle which permits rapid passage of the auricular impulse and premature activation of the ventricle.

Clinical Data

The patient usually complains of palpitation, feeling of fullness in the neck, dizziness, faintness, anxiety or fear, sense of oppression, or precordial pain. Syncope may occur. Observant patients will be aware of the rapid heart action. Although paroxysmal tachycardia starts and stops abruptly, the cessation may be followed by sinus tachycardia, so that clinically the attack may seem to stop gradually.

Physical examination is usually noncontributory, except during tachycardia. The pulse usually is slow, sinus arrhythmia is frequent, and sometimes a split apical first sound is heard. The latter is attributed to asynchronous ventricular contraction.

Diagnosis

Diagnosis is based on the electrocardiogram. The P–R interval is usually 0.10 second or less and QRS is 0.11 second or more. P is not retrograde in contour, and the QRS slurring and prolongation occur in the initial part of the complex. This characteristic initial slurring has been termed the "anomalous component." The electrocardiogram may in a given case contain only normal complexes at one time, only abnormal ones, or both. In a given case over a period of years only one electrocardiogram may show the abnormal complexes. Thus the syndrome may remain undiagnosed for years, either because an electrocardiogram is not taken or because at the time one is taken the accessory pathway is not functioning and only normal complexes are seen.

Differential Diagnosis

Because of the good prognosis, the clinical importance of the Wolff–Parkinson–White syndrome lies in its correct recognition. Misdiagnosis, with its concomitant grave prognosis, is frequent. The most common incorrect diagnoses are bundle branch block, interventricular septal defect, and coronary artery disease.

Treatment

A simple explanation and reassurance are all that are required in most cases. Treatment of the attacks of tachycardia is similar to that of ordinary attacks occurring in the absence of the Wolff–Parkinson–White syndrome, with one exception. The exception is the use of digitalis, which has proved disappointing in controlling paroxysmal auricular fibrillation as it occurs in the Wolff–Parkinson–White syndrome. Paroxysmal tachycardia may cease spontaneously or respond to simple procedures, such as the Valsalva experiment, lowering the head, or inducing vomiting. In other cases, however, even carotid sinus or ocular pressure or mecholyl may not succeed. Quinidine, in adequate dosage, is the drug that is most often successful; for those patients with frequent attacks a maintenance dose is indicated. Roberts and Abramson[2] believe that quinidine selectively depresses the less highly developed and stabilized accessory pathway, thus favoring conduction through the normal pathway. This view is also expressed by Fox and Bobb.[3]

Prognosis

The prognosis is good. The Wolff–Parkinson–White syndrome is ordinarily considered a benign condition. Surgical or obstetric procedures carry no added risk, systemic health is not affected, nor is life expectancy affected. Organic heart disease does not develop any oftener than would be expected in the general population.

Kimball and Burch[4] sound a note of warning and state that because of an occasional death, usually due to uncontrolled tachycardia and circulatory collapse, the prognosis should be guarded. On the other hand, some patients have the typical electrocardiographic findings but never experience cardiovascular symptoms; such persons have an electrocardiographic peculiarity rather than a disease. Movitt[5] cites a few cases in which the electrocardiogram returned to normal over the years and suggests that some persons may "outgrow" their disease; that is, the accessory pathway loses its function with advancing years.

Cardiac Mechanism

The most acceptable explanation is that of Wolferth and Wood.[6, 7] They postulate an accessory rapid conduction pathway between auricle and ventricle. An auricular impulse travels down both the normal and accessory routes, but, because the accessory route by-passes the auriculoventricular node, the "anomalous" impulse arrives prematurely at the ventricle. This accounts for the short P–R interval and the initial slurring of QRS. The later arrival of the impulse travelling down the normal pathway accounts for the final portion of QRS. QRS, then, is ordinarily a fusion complex.[6–9] However, if the P–R time is very short—between 0.06 second and 0.08 second—the rapidly conducted impulse may activate and complete ventricular depolarization and account for the appearance of the entire QRS complex. If this happens, the P–S distance (beginning of P to end of S) tends to be shorter than that of a normal complex of the same patient. Ordinarily, P–S is essentially the same in abnormal and normal complexes of the same patient and is usually 0.26 second less, which rules out bundle branch block.

Any combination of time relationships between the rapidity of spread down the accessory and normal pathways may occur, thus accounting for the marked variation in QRS contour seen in this syndrome. Burch and Kimball[9] describe five main types of QRS and attribute this to varying degrees of delay in the auriculoventricular node.

The paroxysmal tachycardia can also be explained by the accessory pathway concept, utilizing the phenomenon of re-entry. Paroxysmal supraventricular tachycardia and auricular fibrillation can be due to a re-entry of the impulse travelling retrograde along the accessory pathway.[6] Paroxysmal ventricular tachycardia, several cases[10–14] of which have been reported recently, can be due to a re-entry of an impulse originating as a premature ventricular systole, travelling retrograde to the auricle along the normal pathway and re-entering the ventricle through the accessory pathway.[15]

The idea of an accessory pathway has received support from the work of Wood, Wolferth, and Geckeler;[15] Glomset and Glomset;[16] and Rosenbaum and his co-workers.[17] Butterworth and Poindexter[18] produced experimentally an electrical short circuit between auricles and ventricles and obtained the short P–R prolonged QRS pattern; by reversing the flow of current they were able to initiate paroxysmal supraventricular tachycardia.

Report of a Case

The following report of a case illustrates many of the points previously discussed.

History.—Mrs. R.P., a white woman, aged 24, housewife and formerly professional dancer, had her first episode of tachycardia in May 1949. The attack began abruptly as she woke up, consisted initially of precordial oppression, lasted ten minutes, and subsided gradually. She felt weak, but did not perspire and was not alarmed. She was not aware of rapid heart action. The sense of oppression deepened after a few minutes to substernal pain, but did not radiate. She remained in bed an hour, then arose and felt well the rest of the day. She had no suspicion at that time that a cardiac mechanism was implicated.

In June 1949, rheumatoid arthritis developed and the woman was hospitalized. Her second attack occurred while she was in the hospital, with sudden onset of palpitation and sudden cessation. The episode lasted five minutes. She returned home in August 1949 and had two more episodes of palpitation similar to the others.

The fifth and most severe attack began about 11:15 p.m., Oct. 22, 1949, while she was in bed. She felt restless and had a heavy feeling in the chest. Suddenly, very rapid and forceful heart action began; this was the first time she had been aware of tachycardia. Substernal pressure and pain was present. She felt very weak, began to perspire profusely, and felt cold. She became dizzy and stated that she could not "get her breath." She sat up in bed, whereupon syncope occurred and lasted about ten minutes. Upon regaining consciousness, she was panicky and afraid of impending death. The entire attack lasted at least an hour and subsided slowly. By the time she arrived at the hospital, at 2:00 a.m., the pulse was only 104. It was recorded as "rapid and weak."

Past Medical and Family History.—There was no history of cardiovascular disease. The review of systems was noncontributory except for fat intolerance. There was a family history of gallbladder disease; her mother and a sister had had cholecystectomies.

Physical Examination.—The patient was a well developed, not obese 24 year old girl who appeared in good systemic health. The blood pressure was 120/84 mm. of mercury. The pulse rate was 84; it was regular and normal in volume and contour. The size of the heart was normal. Heart sounds were not accentuated; there were no thrills or murmurs; and the first apical sound was not reduplicated. The remainder of the examination was noncontributory.

Laboratory Data.—Urinalyses, performed on Oct. 23 and Nov. 23, 1949, were normal. The sedimenta-

tion rate (Wintrobe) on October 24 was 11 mm. in one hour; on October 26 it was 9 mm., and on November 14, 8 mm. Hematologic examination on October 26 showed 4,800,000 red blood cells, a hemoglobin content of 14.8 Gm., and 11,470 white blood cells, with a normal differential count. On November 23 there were 9,700 white cells, with a normal differential count. The total cholesterol content was 185.2 mg. on October 26 and 152 mg. on Feb. 4, 1950. The mean corpuscular hemoglobin on October 26 was 31 micrograms. Agglutination tests for typhoid, paratyphoid, brucella, and tularense were negative, as was the Kahn test. The icterus index on February 4 was 9 units. The total protein content was 5.4 Gm., serum albumin, 3.6 Gm., and serum globulin, 1.8 Gm.

X-Ray Data.—On Nov. 3, 1949, a posteroanterior teleoroentgenogram of the chest was normal. A repeat chest x-ray on Feb. 3, 1950, was reported as follows: "the size and shape of the heart were normal. The aorta was normal. The lungs were clear."

On Jan. 30, 1950, oral cholecystography revealed a nonfunctioning gallbladder. No stones were visualized. This was repeated on February 4, with the same result.

Progress.—Treatment in the hospital was symptomatic. Quinidine was not given. No tachycardia occurred while the patient was under observation. Chest pain persisted for two days and weakness for four to five days. Oral temperature was normal on admission, then 100 F. a few hours later, and thereafter within a normal range. Serial electrocardiograms (figs. 1–3) revealed the short P–R, prolonged QRS of the Wolff–Parkinson–White syndrome. Flattened and inverted T waves and depressed S–T junctions were prominent features. She left the hospital on Nov. 23, 1949.

At home, she continued to have palpitation on an average of once a week. By this time she was definitely "heart conscious" and taking her own pulse frequently. An electrocardiogram on Dec. 5, 1949 (fig. 4) revealed that evolution to upright T waves and nondeviated S–T junctions was almost complete. Another tracing on November 7 (fig. 5) was almost the same. Atropine sulfate, 1.3 mg. hypodermically, was given and resulted in a faster rate but otherwise no change. A daily maintenance dose of quinidine sulfate, 0.8 Gm. in divided doses, was begun and a three lead electrocardiogram on Jan. 31, 1950, revealed no change in the abnormal complexes; that is, quinidine at this dosage level failed to depress the accessory pathway sufficiently to cause the disappearance of the abnormal complexes.

At least some of her later episodes appeared to be extracardiac in origin. Some were related to excitement and consisted of a sense of pressure of

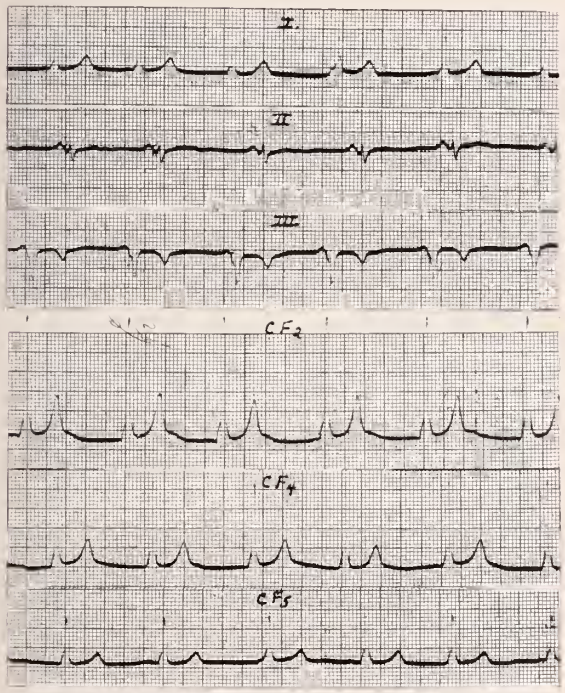

Fig. 1.—Electrocardiogram taken Oct. 24, 1949. The P–R interval was 0.10 second; QRS, 0.12 second; and Q–T, 0.44 second. The electrical systole was prolonged. The rate was 64. There was sinus arrhythmia. P–R interval is short, affecting mainly the P–R segment. Note the "anomalous component"—the initial QRS slurring of small amplitude. T_2 is diphasic, T_3 is inverted, and there is S–T depression in leads II and III.

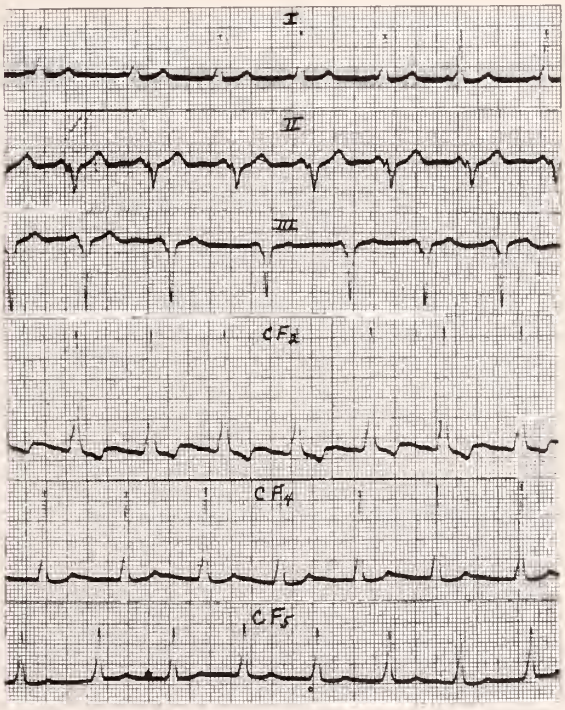

Fig. 2.—Electrocardiogram taken Oct. 27, 1949. The rate was 75. The Q–T interval was 0.40 second. The electrical systole was slightly prolonged. Comparison with figure 1 reveals flatter T_1 and slight depression of S–T in all the limb leads. Configuration of QRS has changed, particularly in lead II. There are marked changes in precordial leads, consisting of flattening of the T waves and S–T depression.

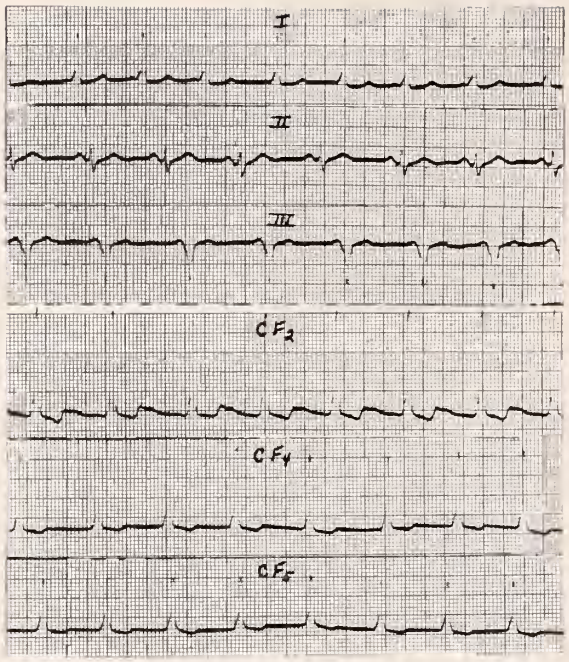

Fig. 3.—Electrocardiogram taken Nov. 3, 1949. The S–T interval in lead I is still depressed and T_1 lower. In the precordial leads there is still S–T depression and the T waves are even flatter. The rate was 75. The Q–T interval was 0.38 second. The electrical systole is now normal.

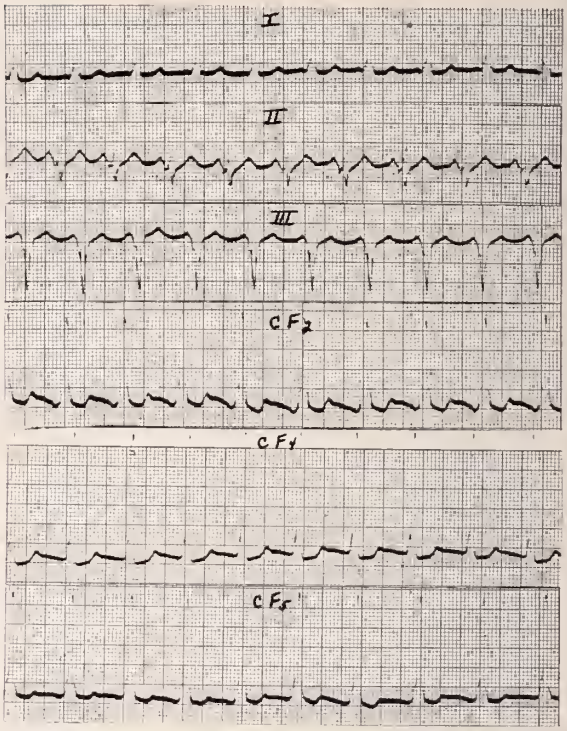

Fig. 4.—Electrocardiogram taken Dec. 5, 1949. The Q–T interval was 0.34 second. The electrical systole was just within normal limits, despite faster rate. In the limb leads, there is no longer S–T depression and the T waves are all upright. In the precordial leads, T is now small and upright in CF and less flat in CF_4 and CF_5. S–T depression is still seen in CF_4. The evolution to a stable form is practically complete.

gradual onset, but without tachycardia. Others consisted of pain, but of a different character and distribution than that described earlier. The pain was at the xiphoid level, epigastrium, and right upper quadrant with radiation straight through to the back. Careful questioning elicited a history of fat ingestion prior to such attacks. On one occasion she was observed over a four hour period and had no tachycardia, but did have right upper quadrant guard and tenderness. It was felt that not all her symptoms could be correlated with the Wolff–Parkinson–White syndrome. Quinidine was discontinued. Cholecystography was done on two occasions and revealed a nonfunctioning gallbladder. Typical biliary colic continued and she was again hospitalized on Feb. 3, 1950. Cholecystectomy was performed on February 6, with the patient under general anesthesia (pentothal followed by nitrous oxide and curare). No special medications were given during operation, and her course during and after the operation was uneventful. The gallbladder was found to be dilated and packed with stones. At the present time she is still convalescing from her operation, but has a healthy attitude toward her cardiac anomaly.

Discussion

This case report presents the usual clinical features of Wolff–Parkinson–White syndrome, complicated later by emotional factors and attacks of biliary colic. The electrocardiographic records are classic. The relationship between cholecystitis and the attacks of tachycardia is interesting, but speculative.

The main problem in differential diagnosis was between infarction and the post-tachycardia syndrome. This was rendered difficult because marked T wave changes can occur spontaneously in the Wolff–Parkinson–White syndrome, as Palatucci and Knighton[11] have noted. A correct diagnosis was arrived at by a critical evaluation of the history, the normal laboratory findings, and the electrocardiograms which were characteristic of the post-tachycardia syndrome.

The post-tachycardia syndrome may occur after prolonged or repeated episodes of tachycardia. Depending on its severity, reversible cardiac enlargement may occur. The electrocardiographic findings, according to Cossio and Berconsky,[19] are depression of S–T, inversion and widening of T, and prolongation of electrical systole (Q–T interval). Katz[20] describes S–T depressions and T flattening or inversion. Such changes may persist for two weeks or longer, and the evolution may superficially resemble an atypical coronary pattern. The electrocardiographic changes are an expression of the transitory coronary insufficiency occurring as a result of the tachycardia.

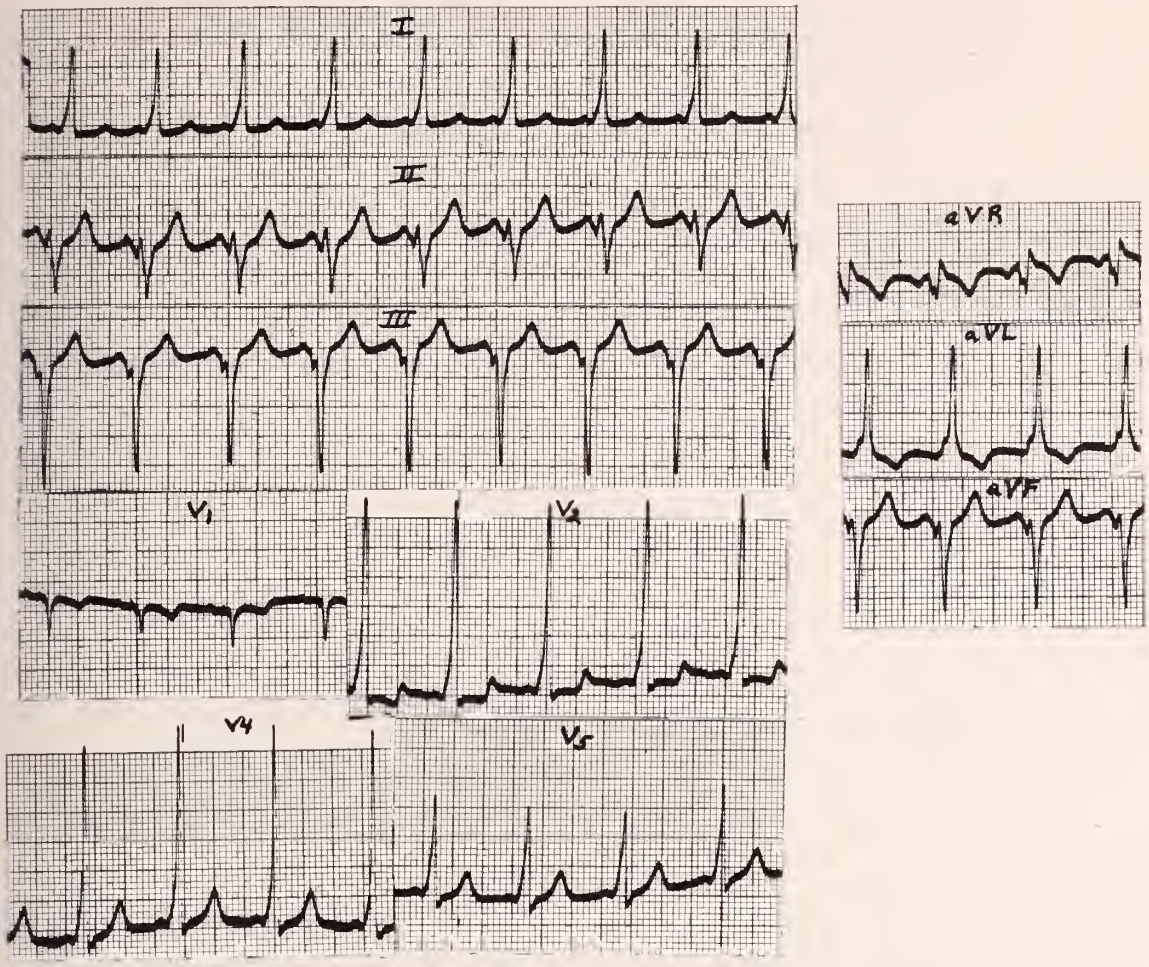

Fig. 5.—Electrocardiogram taken Dec. 7, 1949. Unipolar leads. The rate was 94. The Q–T interval was 0.34 second. The electrical systole was within normal limits. The "anomalous component" is very distinct. In the standard limb leads, there is no S–T depression and the T waves are upright. In the precordial leads, T is slightly taller. The electrical axis is horizontal, which is expected with the left axis shift seen in the standard limb leads. The P–S interval is 0.22 second, which rules out bundle branch block. The configuration of the precordial leads also is not that seen in block.

It might be well to emphasize the usual benignity of the Wolff–Parkinson–White syndrome, and point out that this patient in her short lifetime has already engaged in strenuous activity as a dancer, had an uneventful pregnancy, and has undergone general anesthesia and a major procedure for an unrelated condition, all without incident.

Summary

A review of the Wolff–Parkinson–White syndrome has been presented and the cardiac mechanism discussed. A case is reported which illustrates the typical clinical and electrocardiographic findings required for diagnosis. Electrocardiograms are shown which illustrate the S–T–T changes of the post-tachycardia syndrome, following a bout of rapid heart action.

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MISSISSIPPI VALLEY MEDICAL SOCIETY ANNOUNCES 1951 ESSAY CONTEST

The eleventh annual essay contest of the Mississippi Valley Medical Society will be held in 1951. The Society will offer a cash prize of $100, a gold medal and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents and citizens of the United States. The winner will be invited to present his contribution before the sixteenth annual meeting of the Mississippi Valley Medical Society, to be held in Peoria, Ill., September 19–21, 1951. The Society also reserves the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions must be typewritten in English in manuscript form, submitted in five copies, not to exceed 5,000 words, and must be received not later than May 1, 1951.

Further details may be secured from Harold Swanberg, M. D., Secretary, Mississippi Valley Medical Society, 209–224 W. C. U. Building, Quincy, Illinois.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Mercurial Diuretics

At the present time there appears to be increasing favor in the employment of organic mercurial compounds for their diuretic effects. Causes for such increased popularity in the use of this family of drugs seem to be: (1) the development of chemicals which may be administered by less hazardous routes than the intravenous one which was employed originally; (2) compounds which it is claimed are less toxic; and (3) compounds of greater potency. An examination of the actual scientific evidence for or against each of these causes and a brief review of the facts known regarding the mechanism of action of mercurial diuretics would seem justified.

While the diuretic action of the inorganic mercurous compound, calomel, was known in medieval times, organic mercurial drugs have been so employed only in the past three decades. It is considered generally that the diuretic effects produced on the kidney are due to the proportion of the mercury compound which is ionized (Goodman and Gilman); yet no systematic study of presently used mercurial compounds is available to substantiate this hypothesis. A very pertinent study recently completed[1] indicates a correlation between the diuretic action of mercuric compounds and the inhibition of the succinic dehydrogenase enzyme system of the kidney. While this system is blocked by the presence of mercury, there is quite marked interference with tubular reabsorption of the sodium ion and of water. Thus, these two constituents, the chief excretory products resulting from the action of mercurial diuretics, are present in increased quantities in the urine. Since the succinic-dehydrogenase enzyme system is based on the unique properties of sulfhydryl-containing substances, addition of this chemical group (–SH), as with BAL, almost immediately restores normal function to the renal tubular cells and loss of sodium ion and water is curtailed.

In view of the above mechanism which was so clearly demonstrated by Handley and associates, one is skeptical of even equivalent potency of certain new mercurials where a sulfhydryl (-thiol) group has been added to reduce toxicity. Such mercurials admittedly can be given even by the intravenous route without the hazard of acute cardiac reactions, which was a real danger in older compounds which required intravenous administration. Their resultant diuretic effect should be lessened, not increased. Evidence in the literature now indicates that there is such a reduced diuretic action. In addition, despite reduced initial acute toxicity, the presence of the thiol group ultimately seems to increase the chronic toxicity of such mercurial drugs, accompanied by a decreased renal activity.

There is now adequate proof that several drugs of the mercurial diuretic group may be injected subcutaneously or intramuscularly without causing significant discomfort or local tissue reaction. No longer can one justify the intravenous route of administration of mercurials, in view of the possibility of fatal cardiac accidents. In combination with vitamin C, tablets of several of the drugs have been used orally, daily, and in certain instances a parenteral dosage of the drug is given every five to seven days to maintain the so-called "dry weight" of an individual. If water loss, which is facilitated greatly by increased excretion of the sodium ion, is all that is desired for a patient, some member of the mercurial diuretic family of drugs may well be adequate.

In impaired renal function, however, when blood urea nitrogen is increasing, one must remember that this important catabolic constituent is not effectively reduced by the mercurial diuretics. In fact, there is a real hazard at such times because of the possible toxic effects mercury may have on the cells of the proximal convoluted tubules, accompanied by an even further increase in non-protein nitrogen content of the blood as water is excreted. Thus, at the time of greatest need for greater over-all renal action, this family of drugs is contraindicated. They thus are useful only when augmented fluid and sodium excretion are beneficial in the treatment of the patient.—O. S. Orth, M. D.

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AMERICAN COLLEGE OF CHEST PHYSICIANS TO PRESENT POSTGRADUATE COURSE

A postgraduate course in diseases of the chest will be sponsored by the Council on Postgraduate Medical Education and the Southern Chapter of the American College of Chest Physicians at Vanderbilt University School of Medicine, Nashville, Tenn., January 22–27, 1951.

Inquiries concerning the presentation should be addressed to the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Congenital Gastrointestinal Obstruction

More than twenty years of experience in necropsies of the newborn, although not extensive numerically, has led the writer to conclude that congenital obstruction of the digestive tract is in most hospitals a neglected subject.

The amazing strides of surgical technic, and the increasing knowledge of electrolytes and fluid balance offer early treatment with a fair rate of survival. Early diagnosis and optimistic attitude are of utmost importance. No other visceral system presents such usual obvious diagnostic clinical manifestations. Any newborn infant that peristently regurgitates the feeding should be studied by a team composed of the delivering physician with the consulting pediatrician and surgeon. The purpose of this brief paper is to outline the salient diagnostic observations of the usual congenital gastrointestinal obstructions amenable to surgical treatment.

Diaphragmatic Hernia (most common on left side).—

1. Attacks of cyanosis after or during feeding with tendency to vomit.
2. Accelerated respiratory rate.
3. Auscultation elicits peristaltic sounds and heart pushed to the right.
4. Roentgenograms reveal partial atelectasis of left lung and heart shifted to the right.

Atresia of the Esophagus (with or without tracheoesophageal fistula).—

1. Prompt regurgitation during feeding.
2. Excessive mucus.
3. Attacks of cyanosis after feeding.
4. Passage of catheter down the esophagus will demonstrate obstruction (usually in proximal third).
5. Fluoroscopic examination as 1 or 2 cc. of lipiodol is passed will locate the blind end of the esophagus and air-filled intestines prove atresia associated with tracheoesophageal fistula.

Atresia or Stenosis of Intestine:

1. Vomiting of bile-stained fluid soon after birth.
2. X-ray of abdomen without contrast medium will reveal the approximate region of obstruction, since no gas will be seen beyond the atresia.
3. Duodenal obstruction will cause distention of the upper abdomen.
4. Ilial obstruction will produce generalized abdominal distention

NOTE: No barium for x-ray visualization should be given because it may be aspirated when baby vomits. It may also be a hazard postoperatively by becoming inspissated enough not to pass through anastomosis.

Valvulus (usually due to malrotation and faulty development of mesenteric attachment).—

1. Characteristic picture of acute intestinal obstruction.
2. X-ray will reveal dilated stomach and duodenum and only small bubbles of gas beyond the duodenum.

Imperforate Anus.—

1. Immediate postpartum objective finding
2. Usually associated with some type of fistula (restovaginal, rectoperineal, rectovesical or rectourethral).

Meconium Ileus:—

1 Bile-stained vomitus slightly delayed but usually within 24 hours.
2. Gradual and progressive abdominal distention.
3. Plain roentgenogram of abdomen.

—S. B. PESSIN, M. D.

MARQUETTE UNIVERSITY MEDICAL SCHOOL PRESENTS DIABETES MELLITUS COURSE

Marquette University School of Medicine will present a course on diabetes mellitus at the university auditorium on February 17, beginning at 9 o'clock in the morning. The faculty will consist of Drs. W. W. Engstrom, endocrinologist who joined the university staff this fall; B. J. Peters, assistant clinical professor of medicine; J. E. Conley, clinical instructor in surgery; F. D. Murphy, clinical professor and director of the division of medicine; and F. H. Haessler, professor and director of the division of ophthalmology.

A fee of $5.00 will be charged for the course; attendance will not be limited.

Further inquiries concerning the presentation should be addressed to Dr. E. A. Bachhuber, Assistant Dean, Marquette University School of Medicine, Milwaukee County General Hospital, Milwaukee, Wisconsin.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

F. A. BULL

Doctor Bull, a native of Wisconsin, is a 1923 graduate of the Marquette University School of Dentistry. He was in private practice from 1923 to 1936, when he became supervisor of Dental Education with the State Board of Health. He received the degree of M.S.P.H. at the University of Michigan in 1940. In August 1950 he was named director of dental health with the State Board of Health.

Water Fluoridation

At the 1950 American Dental Association meeting in Atlantic City, N. J., the House of Delegates on November 2 unanimously adopted the following resolution relative to water fluoridation:

> "*Resolved*, that in the interest of public health, the American Dental Association recommends the fluoridation of municipal water supplies when the fluoridation procedure is approved by the local dental society and utilized in accordance with the standards established by the responsible health authority."

The week before, on Oct. 26, 1950, the State and Territorial Health Officers passed a similar resolution recommending water fluoridation. The United State Public Health Service adopted such a resolution in June 1950.

These resolutions followed the example set by the Wisconsin State Board of Health and the Wisconsin State Dental Society back in 1945 when both bodies passed resolutions recommending fluoridation of public water supplies. Now the final stamp of approval has been given this important public health measure for the control of dental caries.

The fact that 75 per cent of the population of the state of Wisconsin having public water supplies have already adopted a program of water fluoridation speaks well for the progressive attitudes of the local medical and dental societies on public health matters. The following communities are either adding fluorides to their public water supplies or are installing equipment to do so in the immediate future:

Cities in Wisconsin Now Fluoridating Their Public Water Supplies

Antigo	Beloit	Edgar
Appleton	Bloomer	Edgerton
Ashland	Columbus	Elkhorn
Baraboo	Crestwood	Evansville
Fond du Lac	Middleton	Rhinelander
Fort Atkinson	Mukwonago	Richland Center
Hartford	Neenah	Sheboygan
Janesville	Oregon	Soldiers Grove
Madison	Oshkosh	Stoughton
Marshfield	Port Washington	Sun Prairie
Mayville	Racine	Waupun
Menasha	Reedsburg	West Bend

Cities in Wisconsin That Have Approved Fluoridation of Their Public Water Supplies—Equipment Being Installed

Athens	Lake Geneva	Prairie du Sac
Beaver Dam	Lake Mills	Ripon
Belleville	Lodi	Shawano
Berlin	Marinette	Shell Lake
Boscobel	Mazomanie	South Milwaukee
Darlington	Mellen	Sparta
Delavan	Menomonee Falls	Tomahawk
Eau Claire	Milwaukee	Watertown
Fennimore	Minocqua	Waunakee
Glidden	Neopit	Wausau
Hurley	Orfordville	Westby
Johnson Creek	Phillips	Weyauwega
Kenosha	Portage	Wisconsin Rapids
Keshena	Port Edwards	

Sheboygan was the first city in Wisconsin to begin the fluoridation of its public water supply, beginning February 1946. Following three and one-half years of fluoridation the dental caries attack rate has been reduced 40 per cent in the deciduous teeth at the kindergarten age and 24 per cent in permanent teeth at the fourth grade level. The dental survey following four and one-half years of water fluoridation at Sheboygan has been completed. The kindergarten group is now showing 46 per cent less dental decay, and the fourth grade group is showing 31 per cent less dental decay than was found before water fluoridation was instituted. At the present time, 43 per cent of these kindergarten children are completely free from any dental caries experience; formerly, only 20 per cent were so fortunate.

The first published data showing the improvement in dental health following water fluoridation were on the Sheboygan program, and these have had a most stimulating effect in bringing water fluoridation to its present status throughout the country. Recently Newburgh, New York; Brantford, Ontario; Marshall, Texas; Grand Rapids, Michigan; Lewiston, Idaho; and Evanston, Illinois, have all reported similar reductions in dental decay rates following fluoridation. It will take another eight to ten years, however, before the full benefit of water fluoridation can be demonstrated in the permanent teeth.

The cost of installing equipment to fluoridate a public water supply varies from $450 in the small community to $3,000 in the larger cities. The cost of the chemicals used for fluoridation varies from 5

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Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editors—LUCIEN E. MORRIS, M. D., Madison, Wisconsin*
and RICHARD FOREGGER, M. D., Milwaukee, Wisconsin

IT IS not surprising that difficulties are often encountered during the use of anesthetics, since these are the most potent depressant drugs used in medicine. Mature judgment and meticulous care are needed in the discharge of the utmost skill to guide each patient safely through the period of anesthesia during which vital functions are necessarily depressed in the effort to provide adequate surgical conditions. Such judgment is the result of knowledge, training, and experience. Since no single individual's experience may adequately encompass all types of difficulties and mishaps, a system for sharing such experiences has been adopted by the Wisconsin Society of Anesthesiologists. Comments upon and evaluation of selected cases are intended to direct attention to considerations sometimes overlooked, awareness of which may reduce the incidence of certain "type accidents" and thereby indirectly increase the safety of Wisconsin patients. Anonymity will be maintained. Your participation is invited.

CASE 25.—An obese white male age 53, weight 210 pounds, was operated upon for incarcerated umbilical hernia during ether anesthesia. Subsequent to operation there was a transfusion reaction with a temperature elevation to 105 F. Oliguria occurred, and albumin and a few red cells were observed in the urine. There was an increase in nonprotein nitrogen to 150 mg. per cent and creatinine to 4.4 mg. per cent. Although the temperature returned to normal and the patient's general condition seemed to improve, a dehiscence occurred on the ninth postoperative day which necessitated a secondary closure. Preoperative medication of 8 mg. of morphine sulfate and 0.3 mg. of Scopolamine was given subcutaneously one-half hour before induction of anesthesia. On arrival in the operating room, the patient's blood pressure was 130/95, pulse rate 84, and respiratory rate 30. Cyclopropane was used for the induction of anesthesia, and maintenance was with ether in a circle absorption system. Relaxation was difficult to obtain, so deeper anesthesia was provided which was associated with a brief period of apnea and moderate cyanosis. Forty-five minutes after induction the blood pressure decreased to 80/50 and remained at that level in spite of a change in position to mild Trendelenburg and the cautious use of Neosynephrine. At the completion of the surgical procedure, which lasted 90 minutes, blood pressure was 80/50, pulse rate 120, and respiratory rate 40. The skin was warm and moist and not cyanotic.

When the patient was transferred to the cart, cyanosis appeared and respirations became somewhat labored. Oxygen was given, the cyanosis disappeared, and the respirations became slower and less labored. As the patient was moved into the corridor, he again became cyanotic, with labored respirations and an imperceptible pulse. He was ventilated with oxygen, and vasopressor substances (quantity and kind unreported) and coramine were given. Color of the skin and quality of the pulse improved, so he was sent back to his room with a nasal catheter in place for the administration of oxygen. When moved into his bed it was noted that respirations had ceased and that the pulse was not palpable. Artificial respiration was performed and Neosynephrine was given but to no avail. Vital functions did not return. An autopsy was not allowed.

Comment

The condition of the patient, the uremia, the toxicity, the weight and size of the patient, and the necessity for secondary closure are all among the directly contributing factors in the death of this patient. In addition, it seems to us that the management of the anesthesia may have been a factor also. Morphine was given hypodermically as part of the preanesthetic medication only one-half hour before operation. Ordinarily the full depressant effect of morphine upon circulation and respiration appears only after about an hour and one-half. The morphine effect of gradually increasing depression of respiration was possibly the factor which caused a state of chronic hypoxia which led to circulatory distress, confused the evaluation of depth of anesthesia, and accounted for lack of relaxation. It is possible also that due to decreased ventilation there may have been atalectasis of one or more lobes of the lungs which would account for the cyanosis.

There is no information given as to the presence or absence of reflexes at the end of operation, but the probability is that reflexes were rather well depressed. Each time in the postoperative period that the patient became cyanotic and respirations labored, ventilation with oxygen was followed by improvement in the patient's condition; then respirations would become less forceful and the patient's condition would revert to one of cyanosis and difficult breathing again. This suggests the possibility that the respiratory center was so depressed that it no longer responded to the normal stimulation of

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Proceedings of the Milwaukee Academy of Medicine October 17, 1950

Lesions of the Lumbosacral Spine

By PAUL WILLIAMS, M. D.
Dallas, Texas

HUMAN posture is completely unique within the biologic world in the fact that man maintains a massive super-structure on a small base of support. The erect attitude is not permanently sustained in any of the other forms of life. The balance of the massive superstructure rests on the relationship of the center of gravity of this mass to the position of the feet. The feet can move within a 5 foot diameter in all directions and thus maintain balance and erect attitude at all times. The human characteristic has developed over a long period of time and has resulted in some rather serious alterations in muscle relationships. Certain muscle groups, such as gluteus maximus, hamstrings, quadriceps, and iliopsoas, are associated with a completely different function in man than they are in the lower animals. This has been brought about by changes in relationship of the origin and insertion due to changes in the body position. Briefly, in man this is as follows. The gluteus maximus has an attachment completely posterior to its origin. The hamstrings no longer have a particular extension function, as the tuberosity of the ischium, their origin, has moved almost directly under, and in this straight position their function is more or less lost. The same is true of the psoas muscle, which is not a hip flexor until the hip is flexed to approximately 30 degrees, when the psoas takes hold and continues as a strong hip flexor. In the upright body attitude most of its energy is expended in a vertical compression. Furthermore the psoas muscle takes its origin from the transverse processes posterior to the lumbar vertebral bodies, and it actually has become an extensor of the lumbar spine in the vertical position.

In this story of evolution the human hip joint has been satisfactorily maintained; however, the lumbosacral spine has had to undergo a terrific change. It has become a weight-bearing structure and is in a position of a greater or lesser degree of lordosis. Therefore, not only is the vertical position considered erect but frequently is hypererect, and weight is transferred from the vertebral bodies to the articular facets. It is the intervertebral disk which furnishes intervertebral support. Hypererect attitudes may injure the disk, and its cushioning support is then gone. Then the articular facets become weight bearing and suffer degenerative changes, such as lipping, sclerosis, etc. In the normal relationship of the facets there is a round, comma-like space between the superior first sacral facet and the inferior vertebral notch of the fifth lumbar vertebra. This allows ample space for the nerve, its fat, and blood vessels. When the vertebral facet has become a weight-bearing structure due to disk changes, the superior first sacral facet becomes lodged in the intervertebral notch of the fifth lumbar vertebra and physical compression of the nerve takes place.

The most important problem of diagnosis is proper x-ray technic to demonstrate this finding. We advise a lateral x-ray which is immediately developed and examined for the tilt of the sacral table. We then take a stereo anteroposterior x-ray, with the tube inclined according to the sacral tilt as determined on the lateral view. Following this, we take a single oblique projection of the lumbosacral spine again, with the tilt of the tube adjusted according to the above. The frequently seen x-ray changes are those of subluxation or posterior displacement of the fifth lumbar vertebra. This is usually accompanied by narrowing of the intervertebral space. This is followed by degenerative marginal changes of the superior first sacral facet and degenerative changes in the inferior intervertebral notch of the fifth lumbar. One also may see porosis of the inferior intervertebral facet. The demonstration of this as the cause of low back pain is related to the care with which x-ray examination is carried out. The proper x-ray technic will rule out most other considerations as a cause of low back pain.

The initial change which sets off this lumbosacral relationship is that of intervertebral disk collapse or rupture. I am convinced that 60 per cent of the adult population have a collapsed intervertebral disk. Only about 10 per cent of such patients actually have a protruding disk that is causing severe symptoms and in whom operation is the treatment. The background of the disk difficulty is related to abuses of the lumbosacral spine. Some 20 per cent of youngsters show collapse of the fifth lumbar disk. In such patients, however, nuclear material is gelatinuous, is rapidly absorbed, and does not produce any particular difficulty until the degenerative changes have developed in the facets. This is in great measure associated with the extension of the spine, and it is an experience of all of us that the neck and lumbosacral areas are the favorite points for vertebral pain. Many of these disk diseases stem from bad postures alone. Particularly important is

the military attitude, which is associated with a forward position of the chest, shoulders back, and, naturally, an increasing lordosis. As lordosis is increased, the weight of the super-structure is thrown on the posterior aspects of the disks, and as degenerative changes occur here, then the weight is shifted to the articular facets. History brings out many similar situations and customs. Sleeping on the abdomen is one very frequently elicited. The female in dancing develops a marked degree of lordosis by gazing upward at a partner taller than she who proceeds to waltz her backwards most of the time. Next is theater sitting which cannot be done comfortably because of the slope of the floor. The feet do not touch the floor and the knee becomes lower in position than the hip. This increases lordosis and results in pain. The natural thing then is to raise the knee on the back of the seat in front of you. Prolonged standing does the same. Bending over a wash basin or bending over to lift an object with knees straight is a severe force placed upon the lumbar vertebra by the powerful erector spini muscle group. One need not mention that in such a forward attitude of the trunk one must support the weight of the body and arms and load against gravity. With the knees straight, this can only be done by the spinal erector group, which means severe extension of the lumbosacral area. Positions of the arms above the head for any period of time may also bring about such a difficulty or its painful sequence. Exercise involving back bends is notorious in youngsters in causing crushed intervertebral disks.

In the correction of the bad postural situations, a few simple anatomic features must be remembered. The erector spini muscle groups lift the pelvis from behind. The abdominal muscles work in opposition and they tend to lift upward the front of the pelvis. The gluteus maximus works with the abdominal muscles, but, since it is not frequently exercised and often sat on, it undergoes atrophy. The purpose in therapy, then, is to stretch the spinal muscle group and to strengthen the abdominal and gluteus muscles. Exercises are devised for that particular purpose. Briefly some of the points to remember are these: 1. When walking or standing, toes should point straight ahead and most of the super-structure weight should be on the heels. This means somewhat of an ape attitude in walking. 2. One should hold the chest upward and forward but at the same time elevate the forward part of the pelvis by abdominal muscle activity. That further means that any bending over to lift objects, to tie shoe strings, or whatever it may be one must use the squat attitude rather than bending at the hips. 3. Elevate the knees when sitting and driving. 4. Sleep on the back with knees propped if necessary. 5. Do not carry weights in front of you and above the waistline. 6. Never bend backwards. 7. Avoid standing as much as possible. 8. Learn to live 24 hours a day without hollowing the lower part of the back. The precise exercises to fullfil these points are given in detail in the July 1937 issue of the *Journal of Bone and Joint Surgery* (vol. 19, page 690) and Instructional Course of American Academy of Orthopedic Surgeons, 1947, page 103.

WISCONSIN ANESTHESIA STUDY COMMISSION OF THE WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

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the increased carbon dioxide and that respirations in this period were maintained by a chemoreflexive anoxic drive from the carotid body. When the patient was moved from the operating room to his own room, oxygen was continuously supplied, and the so-called anoxic drive toward respiration may have been thereby removed. In the absence of continual medical observation at this time, obstruction probably occurred due to depression and may have been of sufficient duration to account for the respiratory failure and death, in this instance from asphyxia. When respiration is depressed it may be necessary to assist ventilation for a considerable length of time in order that transport of oxygen and carbon dioxide can be satisfactorily maintained. In addition, sudden changes in position such as are often encountered during the difficult moving of patients of this size, also may occasionally cause disturbances in circulation of a serious nature. Any one or all of these factors may have contributed to the final outcome. Unconscious postoperative patients must be kept under close medical surveillance until it is certain that they can reflexly maintain their vital functions without aid. The administration of analeptic drugs will not take the place of ventilation with oxygen.

AS IT LOOKS TO YOUR STATE BOARD OF HEALTH

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to 10 cents per capita annually depending upon which chemicals are used.

While 75 per cent of our people having a public water supply have adopted a program of water fluoridation, there still remain 25 per cent who have not availed themselves of this opportunity. Most of these people are in the smaller communities, and it will take considerable effort on the part of physicians, dentists, and public health personnel to stimulate them to adopt such a program. In the interest of our future generations, it is hoped that all communities will have fluoridated water in the near future.—F. A. Bull, D.D.S., M.S.P.H., *Director of Dental Health.*

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M; D. University of Wisconsin Medical School, Madison

Presentation of Case*

J. B., a 49 year old white male, was admitted to the hospital on Dec. 3, 1949, and expired on December 28. On admission he complained of exertional dyspnea and orthopnea. He dated the onset of these symptoms to December 1948, when, after a "bad cold" there developed dyspnea and "dropsy" involving the abdomen and the lower extremities. Two weeks of treatment, consisting of rest, pills, and injections, effected an improvement. He denied ever having experienced paroxysmal nocturnal dyspnea. Gradual improvement was noted until the summer of 1949, when he again had a similar episode. Improvement again followed treatment, although a persistent cough productive of white phlegm developed. Three weeks prior to admission there had been another episode of dyspnea and edema following a severe cold. The cough became more severe, and this time productive of a rust brown sputum, occasionally flecked with blood. During this period he had lost about 75 pounds. Appetite was fair and he had no symptoms attributable to a gastrointestinal disorder. Nocturia (one to two times) was another complaint. He had had rheumatic fever at the age of 15 or 16 years and again when he was 23. However, he had always been able to pass physical examinations for life insurance. He admitted consuming a pint of liquor daily for the preceding five years.

Physical Examination.—His temperature was 99.2 F., pulse rate 84, respiratory rate 25, and blood pressure 200/128.

The patient appeared to be acutely ill. He was dyspneic and was coughing up blood-streaked sputum. He seemed to be mentally alert. Both retinal fundi showed grade II to III arteriosclerotic and hypertensive changes. A dull percussion note, decreased fremitus, decreased breath sounds, and crepitant rales were found over the right lower chest. Crepitant rales were also audible over the left base. The cardiac apex extended to the anterior axillary line, and, although the rate was normal, frequent premature systoles were present. A systolic murmur was audible over the precordium. The abdomen was distended and shifting dullness was demonstrable. The distention precluded satisfactory palpation. There was marked pitting edema of the legs.

Roentgenographic Findings.—Examination of the chest on December 8 disclosed an enlarged heart; bilateral pleural effusion, greater on the right side; and patchy infiltration suggestive of pneumonic process on right side. Excretory urography on December 8 showed impaired function and apparent enlargement of both kidneys; non-opacification of the caliceal systems; and opacification of urinary bladder on a two and one-fourth hour film. There was enlargement of the liver and spleen.

Laboratory Findings.—Examination of urine on December 4 revealed that it was clear, straw colored, and acid. Specific gravity was 1.006, and it contained 3 plus albumin, no sugar, and 5 to 8 white blood cells. On December 12 examination showed it to be turbid, straw colored, and acid, with a specific gravity of 1.006, 4 plus albumin, no sugar, many red blood cells, and occasional white blood cells.

Hematologic examination on December 4 revealed a hemoglobin content of 13 Gm. (85 per cent), 4,300,000 red blood cells, and 11,600 white blood cells, with 86 per cent neutrophils. On December 19 the hemoglobin content was 11.5 Gm. (75 per cent), there were 3,800,000 red blood cells, 17,900 white blood cells, with 89 per cent neutrophils and 293,000 platelets. On December 24 the hemoglobin level was 11.5 Gm. (75 per cent), and there were 3,800,000 red blood cells and 10,900 white blood cells. The coagulation and bleeding times on December 19 were five and two minutes respectively. The prothrombin time on December 4 was 40 per cent; on December 14, 40 per cent; and on December 17, 35 per cent. The total protein content on December 8 was 7.00 Gm., and the albumin-globulin ratio was 3.44:3.56. Cholesterol and cholesterol esters on December 9 measured 235 and 140 mg. (60 per cent). Cephalin cholesterol flocculation on December 9 was negative after 24 hours and 2 plus after 48 hours. The icterus index on December 14 was 7.7 and the nonprotein nitrogen level on December 14 was 103 mg. and one week later, 222 mg. Specific gravity of the pleural fluid was 1.010, and it contained protein, 2.72 mg. per hundred cubic centimeters, and a few cells, predominantly neutrophils and lymphocytes. There were no tumor cells. On December 17 there was less than 0.2 mg. of ascorbic acid. Vomitus on December 21 was positive for blood. The Kline test was negative. An electrocardiogram on December 6 showed severe myocardial damage (fig. 3), and on December 17 electrocardiographic examination showed myocardial damage, but improvement over the previous one.

Course in Hospital.—For the first seven to eight days the patient's condition remained essentially unchanged. Therapy was directed primarily toward alleviation of the edema by means of diuretics (Mercuhydrin and ammonium chloride), a salt-free soft diet and Cedilanid. Penicillin and Methiscol were also administered. Records showed an average fluid

* From Evangelical Deaconess Hospital, Milwaukee; **Dr. Donald C. Ausman**, clinician; **Dr. Robert S. Haukohl**, pathologist.

intake of about 1,400 cc. and an average urine output of 700 cc. Rales persisted in the chest, particularly over the right lower portion. A prominent feature was hemoptysis, the sputum being pinkish at times and at other times rust colored. However, the temperature varied within the normal range.

An ominous sign was the development of gross hematuria on the ninth day (December 11), and on occasions small blood clots were seen in the urine. This complication led to the discontinuance of the mercurial diuretic. Shortly after, frequent episodes of nausea and vomiting developed. Cedilanid was considered as a possible cause and was, therefore, discontinued. On December 13 a chest tap removed 950 cc. of blood-tinged pleural fluid. About this time physical weakness, mental depression, and an outlook of pessimism were evident.

The appearance of petechial and ecchymotic spots over the extremities on December 16 marked the beginning of the last phase, which was characterized by a fairly rapid downhill course. Almost simultaneously the radial pulse became poor in quality. Eschatin, vitamin C, synkavite and rutin were given, and, although the rash at one time showed a tendency toword fading, its progression and extension to involve the trunk, particularly the dependent regions, were undeniable. An unsuccessful attempt was made to tap the abdomen. The cardiac rate and rhythm continued to fluctuate as the patient became more and more irrational. Persistent hiccups developed and the patient had frequent emeses of dark brown vomitus and involuntary passages of tarry stools. A blood transfusion failed to bring about any noticeable improvement. On December 26, respirations became labored. Cyanosis developed and the patient lapsed into a semicomatose condition. By this time the blood pressure had dropped to about 100/70. Anuria developed, which was closely followed by a rising temperature, muscular twitchings, and signs of dehydration. Increasing respiratory difficulties and a gradual drop in blood pressure to about 50/40 preceded his death on December 28.

Clinical Discussion

Doctor Ausman: The case shows manifestations of disease in various organs, kidney, heart, lungs, stomach and intestines, liver, and skin. The complex symptomatology affects a multiplicity of systems and corresponds to no particular systemic disease. This is in itself unique and suggests a preliminary diagnosis, which will be held in abeyance while other differential diagnoses are entertained to be accepted or discarded.

The cardinal features are frequent respiratory infections leading to heart failure, with signs of dyspnea and dropsy, two bouts of rheumatic fever, one at the age of 15 and the other at 23 (he was 49 at death), hypertension, cardiac disturbance, a low grade fever and leukocytosis, marked loss of weight in a short time, evidence of uremia, and a tachycardia which was more than could be expected from a slight elevation in temperature.

Review by Systems. The Cardiorespiratory System: Several episodes of upper respiratory infection which led to symptoms and signs of congestive heart failure had been present for about one year. The following possibilities then present themselves:

1. Could this be a myocarditis following viral upper respiratory infections? Such have been presented in the literature recently, but this patient had several such attacks, which is unusual, and, in addition, the last affair involved more than just the cardiac system. On this basis this factor should be ruled out.

2. Is this a rheumatic myocarditis? We have more evidence to support such a diagnosis, as this patient had had two episodes of rheumatic fever. It would be entirely reasonable to assume that the respiratory infection was just enough to upset the compensatory balance of a previously damaged heart and throw the patient into decompensation. This diagnosis will not in its entirety explain the gastrointestinal symptoms and urologic symptoms.

3. Is this malignant hypertension? The eye ground changes, the hypertension, cardiac hypertrophy, the age of the patient, the kidney findings and the rapidly fatal outcome lend themselves to such a diagnosis, but will not explain the pulmonary changes and the lack of a strain pattern on the electrocardiogram. The kidneys were reported as enlarged and usually small contracted kidneys are found in malignant hypertension.

It would seem unusual to me for a patient to have two rheumatic fever bouts and then pass life insurance examinations unless his cardiac findings were minimal. I would, therefore, consider this fact strongly in attempting to evaluate other findings which I will mention. In view of the aforementioned minimal endocardial valvulitis, I would expect to find here more myocardial and pericardial changes, such as fibrinous patchy pericarditis and myocarditis.

The cardiac silhouette (roentgenogram of December 8) shows an enlarged left ventricle and a prominent pulmonary conus which could be indicative of a mitralized heart but could also be explained on a basis of chronic lung lesions and chronic hypertension. The mitral systolic murmur could have been due to his heart failure and not necessarily to a mitral valve lesion. We do know that he had had repeated pulmonary infections, but that in itself is hardly enough to give him a cor pulmonale. One would expect to see emphysema, evidences of chronic pulmonary disease, or a congenital heart condition, but there is no evidence to corroborate such diagnostic ventures. We do know that he had a bilateral pleural effusion and that the chest tap revealed evidence of a transudate rather than an exudate. For this reason I would assume that the "pneumonic process" found on the roentgenogram of December 8 was really an infarction. The fact that he showed bright blood changing to a rusty sputum could indicate the usual changes in infarcted lung tissue over a period of time. The oblique views showed numerous other smaller patches, particularly perihilar. The effusion

into the pleura could be a part of the congestive heart failure, but the infarcted areas cannot be explained on this basis. One could assume these infarcts to be due to emboli from rheumatic vegetations, but we discussed before that his valvular changes were minimal and, therefore, would not account for multiple emboli, particularly as the heart was not fibrillating (electrocardiographic evidence). One will therefore have to look further for an explanation of this phenomena.

The Hepatic System: No definite symptoms point to pure liver disease, and the history of the consumption of a pint of alcohol daily for five years may be a "red herring." This worshipping at the feet of Bacchus does not always cause cirrhosis, and, if it did, in this case more than just a 2 plus cephalin-cholesterol flocculation test would be expected. Other evidences of cirrhosis, such as telangiectatic spider nevi, caput medusa, macrocytic anemia, palmar erythema, and pre-cirrhotic habitus are lacking or not mentioned. The lowered prothrombin times are significant of hepatic damage or decreased liver function, as well as a moderately elevated icteric index, which suggests subclinical jaundice.

Gastrointestinal System: The salient symptoms here are sudden loss of considerable weight, tarry stools, nausea, vomiting (due to digitalis intoxication, as evidenced by the re-entry phenomenon on the first of the serial electrocardiograms), and hematemesis. It is difficult to account for these symptoms on a basis of total heart failure, and it would be easier to assume them as being due to ruptured varices concomitant with a cirrhosis of the liver.

Genitourinary System: Nocturia, once or twice a night, was the only entrance complaint. The findings in the urine on entrance were albuminuria 3 plus, low specific gravity, and 5 to 8 white blood cells. In acute glomerulonephritis, hematuria is almost always present, especially if one looks for it by means of an Addis count. This was absent in the first specimen, but strongly present eight days later without evidence of the pyuria which is usually present in glomerulonephritis. Casts usually found in this disease were noticeably absent. A lack of concentrating power of the kidneys is evidenced by the low specific gravity and the excretory urography, which showed practically no concentration of the dye after two and one-fourth hours. The kidneys were reported as being enlarged. Uremia was a salient feature of this patient's difficulties and eventually led to his death with a sudden anuria.

Clinical Conclusion.—The symptomatology is extremely varied because of the number of systems involved, and the symptoms do not correspond to a particular system disease. This is unusual for a disease which could affect all of the organs and give us the bizarre picture this case conveys. Disseminated lupus erythematosus and scleroderma are ruled out by lack of diagnostic skin lesions. The disease in question could be periarteritis nodosa (polyarteritis nodosa), affecting as it does any organ in the body by reason of the blood vessel involvement. This diagnosis could explain (1) the tachycardia without much fever; (2) the leukocytosis; (3) the multiple pulmonary infarctions of varying stages of resolution and acuteness; (4) the "pneumonic process" described on x-ray, which could have been a larger infarct with engorgement and a necrotic center accounting for the leukocytosis and fever; (5) the hepatic findings of diminished function as evidenced by the 2 plus cephalin-cholesterol flocculation tests (The lowered prothrombin times and the subclinical jaundice could be manifestations of this disease in the liver. The enlarged liver and spleen may be explained as due to chronic passive congestion.); (6) the gastrointestinal symptoms which could be due to thrombosis of the mesenteric vessels and those of the celiac axis and a resulting hemorrhagic colitis and peritonitis; and (7) the marked hematuria, with renal failure and uremia which caused his death. The sudden anuria could have resulted from an edematous parenchyma due to multiple infarcts because of thrombotic vessels pressing against an inelastic capsule, or we could add renal artery or vein thrombosis to the picture. The retinal changes could be evidence of an albuminuric retinitis.

I would therefore suggest the possibility of this patient having had:

1. Periarteritis nodosa.
2. Heart disease (etiologic factors: *a.* rheumatic fever, *b.* periarteritis nodosa, and *c.* hypertension; anatomic diagnosis: *a.* mitral regurgitation (relative), *b.* Mitral valve disease minimal, *c.* left ventricular hypertrophy, *d.* cor pulmonale, and *e.* adhesive patchy pericarditis; physiologic diagnosis: total heart failure.)
3. Pulmonary disease (*a.* bilateral hydrothorax, *b.* chronic passive congestion, and *c.* multiple infarctions in varying stages, due to polyarteritis.)
4. Kidney disease (*a.* multiple infarctions (polyarteritis), and *b.* uremia as the cause of death and possibly due to renal artery or vein thrombosis.)
5. Gastrointestinal disease (multiple mesenteric and celiac axis thrombosis with hemorrhagic colitis due to polyarteritis).

Pathologic Discussion

Doctor Haukohl: Postmortem examination revealed a variety of rather interesting lesions. There were numerous petechial hemorrhages in the skin over the anterior body surfaces and extremities. The heart showed evidences of chronic rheumatic heart disease. There was a minimal chronic adhesive pericarditis, chronic fibrous mitral valvulitis, focal areas of myocardial fibrosis and moderate hypertrophy of the left ventricular wall. Cardiac failure was manifested by moderate chronic passive congestion of lungs, liver, and spleen. Both lungs displayed focal areas of atelectasis and of bronchopneumonia. The pleura overlying the right lower lobe was cov-

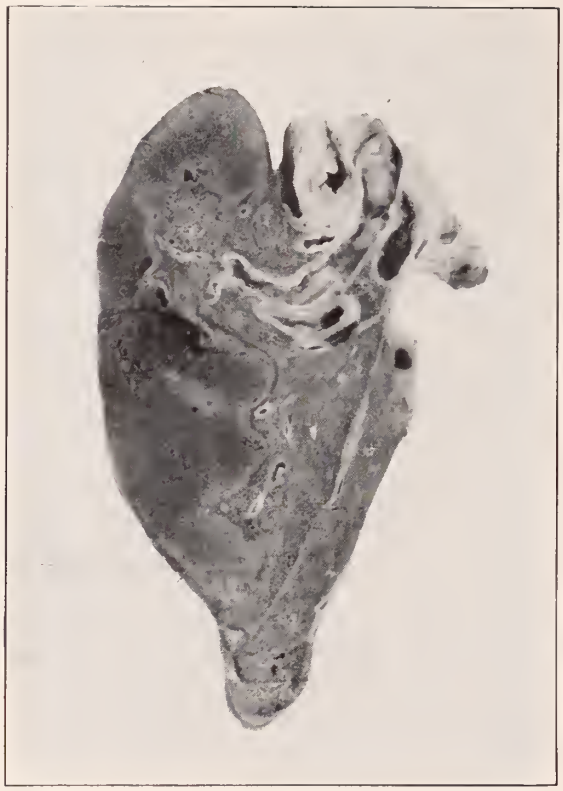

Fig. 1.—Part of lower lobe, right lung, showing the softened and necrotic pulmonary infarct. Note the thrombotic occlusion of the branch of the pulmonary artery.

ered with fibrinous exudate. Section here revealed a large infarct with a central softened zone (fig. 1). A small branch of the pulmonary artery leading to this area was completely occluded by antemortem thrombotic material. The vena cava contained fluid blood, but both renal veins were completely occluded by antemortem thrombi (fig. 2). These extended into the small tributaries and throughout the parenchyma of both kidneys. The renal arteries showed atherosclerosis but were patent. The kidneys weighed 330 Gm. each. They showed mottled, markedly congested deep purplish red surfaces. The tips of several renal papillae showed softening and necrosis. The thrombotic material within the right renal vein appeared to be firmer and better preserved than that in the left. Small foci of softening could be found within the material on the left. Microscopic examination of these kidneys displayed, in addition to zones of infarction, a rather diffuse acute glomerulitis. Terminal uremia was demonstrable anatomically by an acute fibrinous pericarditis and marked hemorrhagic jejunitis and colitis. Microscopic examination of the pancreas revealed tiny foci of necrosis.

To explain this patient's death one must postulate a series of events. Nothing is known of the medication he was receiving prior to coming under observation. The attending physician, feeling that the underlying pathologic change was chronic rheumatic heart disease with failure, administered digitalis. An electrocardiogram (fig. 3) shortly after admission (December 6), however, showed changes compatible with digitalis intoxication, indicating

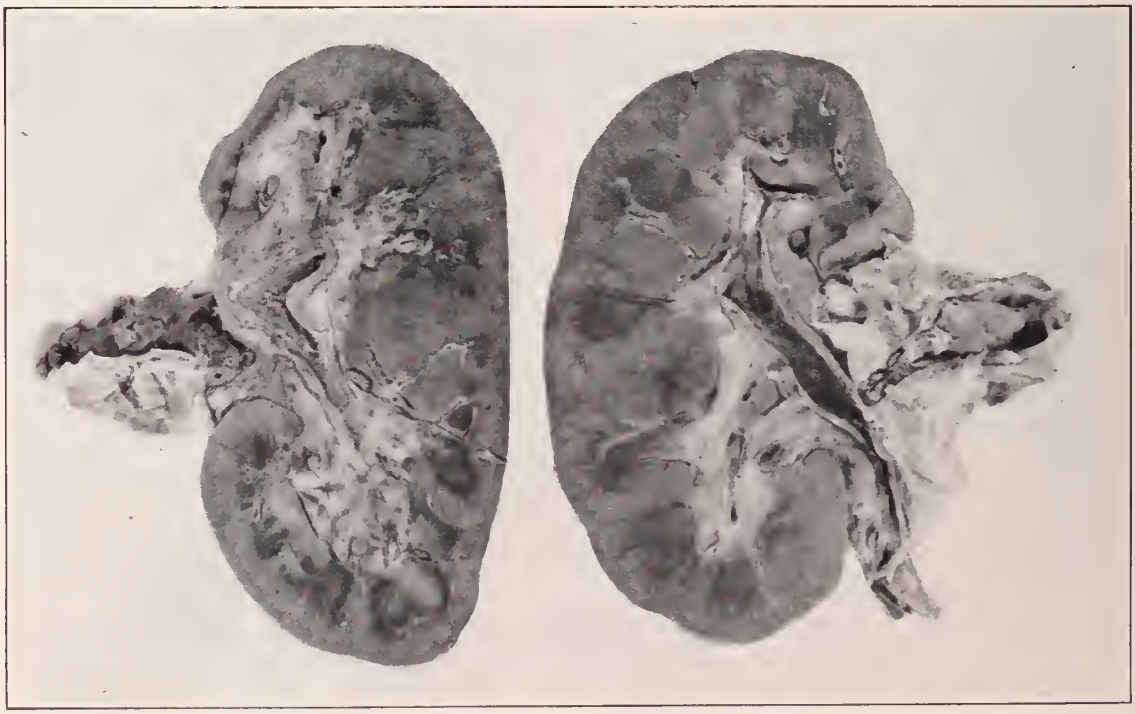

Fig. 2.—Cut surface of both kidneys. The renal veins are occluded by masses of thrombotic material. The kidneys show marked hyperemia.

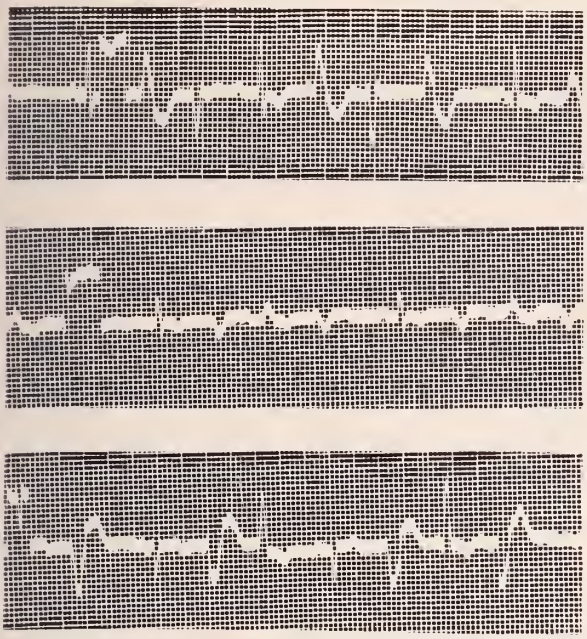

Fig. 3.—Electrocardiogram taken on Dec. 6, 1949. Standard leads I, II, and III. Depressed S-T segments in all leads and the pulses bigeminus and trigeminus indicate digitalis intoxication. A later tracing, after the drug was discontinued, was normal.

that the patient probably had been receiving the drug. For this reason, administration of the drug was immediately discontinued and, as evidenced by a subsequent electrocardiogram (December 17), the cardiac rhythm returned to normal. Probably sometime during this period a small piece of mural thrombotic material broke off from the atrium or auricular appendage on the right side of the heart and lodged in the right lower lobe, giving rise to an infarct. A systemic toxemia or septicemia resulted when the infarcted lung tissue underwent necrosis. This is evidenced by the acute glomerulitis, the cutaneous petechial hemorrhages and inflammatory changes in the skin and pancreas. This, together with slight dehydration, perhaps the additional effect of mercurial diuretics and the stasis accompanying a failing heart, gave rise to thrombosis of the renal veins. The relative ages of the thrombi would indicate that the process began in the left renal vein and later occurred in the right. The patient eventually died of uremia complicated by bronchopneumonia.

Renal vein thrombosis occurring as a complication of pulmonary infarction has been previously described. Although relatively few cases have been reported (228 up to 1945), there undoubtedly are many more instances that have not appeared in the literature. The condition occurs most commonly in infants but has been reported in all age groups with an equal sex distribution. The factors which predispose to thrombosis in other portions of the body, e.g., intimal injury, changes in circulatory dynamics, and changes in the composition of blood, undoubtedly play an important part in renal vein thrombosis. Renal veins most commonly are occluded secondarily to extension of a thrombus from the inferior vena cava, the ovarian, spermatic, lumbar, or adrenal veins. Rarely the thrombosis may be precipitated by embolic occlusion of the renal vein.

The most important primary type of renal vein thrombosis is that associated with inflammatory processes in the kidney or perirenal tissue, including acute pyelonephritis, perinephritis, and local phlebitis. Local pressure from enlarged lymph nodes, a neoplasm, or an enlarged uterus may bring about stasis and subsequent thrombosis. Local trauma to the region or secondary to operative handling of the kidney may precipitate the condition. Infrequently the thrombosis may be due to a primary vascular disease of the kidney, such as periarteritis nodosa, perhaps thromboangiitis of the renal veins, angiospasm, or, rarely, amyloidosis. Finally, the condition may be precipitated by systemic toxemia or septicemia, such as probably occurred in the case under discussion.

The pathologic changes produced in the kidney depend upon the extent of thrombosis. If the renal vein itself is thrombosed, the entire kidney will display hyperemic infarction. The infarct will be of lesser extent if only smaller branches are involved.

Among the clinical features of this condition, the most prominent are pain and local tenderness, sudden in onset. Enlargement of the kidney may be demonstrated by roentgenograms or, in children, by palpation. Thirdly, there is some degree of renal functional impairment, depending upon the extent of involvement. Albuminuria and hematuria are universally present, and, if the involvement is extensive enough, oliguria, anuria, and eventually uremia may result. The condition is accompanied by the constitutional symptoms of toxicity, prostration, shock, and, very commonly, fever and leukocytosis. Nausea and vomiting may be present in children. A characteristic physical finding, especially if there is accompanying thrombosis of the inferior vena cava, is mottling of the abdominal wall and back due to dilatation of subcutaneous veins. Hypertension is usually absent. The diagnosis then must be made on proper evaluation of clinical history and physical examination. The demonstration of an enlarged kidney either clinically or by x-ray is sometimes of help. The prognosis is rather poor. Ninety-five per cent of the infants affected die. A few adults have survived when the condition was unilateral and a prompt nephrectomy was performed. Rare cases of survival without nephrectomy have been observed.

In this case, then, instead of a systemic vascular disease, periarteritis nodosa, we are dealing with a rather unusual systemic complication of rheumatic heart disease and pulmonary infarction.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Directing Board of Blue Shield of Wisconsin, an Agency of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

What is Meant by "Full Payment"?

Under certain conditions, the physician who signs a participation agreement with Blue Shield of Wisconsin (Wisconsin Physicians Service) agrees to accept as full payment the scheduled benefit provided for usual services to persons covered by the plan.

This agreement to make no added charge to the subscriber is binding when the *individual* subscriber's income is less than $2,000 a year, and when the *family* subscriber's income together with that of his dependents is less than $3,600 per year.

EXCEPTIONS:

When incomes exceed these limits, the physician is no longer bound by the "full payment" feature and may make such additional charges as he feels are appropriate.

The physician is also free to bill the subscriber for any services for which benefits are not provided by the Blue Shield Contract. This includes such services as medical care during the first three days or after the thirteenth day of each hospital admission.

The full coverage provision does not apply when a patient has coverage under Blue Shield and also receives payment from another insurance policy. Physicians are cautioned to use this exception with discretion inasmuch as the other insurance policy may provide only a very limited benefit or may be held by the insured for reasons which bear consideration by the doctor.

What Surgical Services are Included in a Blue Shield of Wisconsin Contract?

Under the Blue Shield contract, surgical services mean those operative and cutting procedures recognized by the medical profession in the treatment of disease and injuries, and shall include the treatment of burns, fractures, and dislocations.

Surgical services covered in the Blue Shield of Wisconsin contract include emergency surgery performed *anywhere* by a doctor of medicine when such service is required as a *result of accidental injury* and is provided *within 24 hours* of such injury.

Also included is all surgical treatment performed within a hospital, whether as an outpatient or as a bed patient, *unless* specifically excluded by the Blue Shield contract. The excluded items are:

1. Services for industrial injuries or diseases, or services from any governmental agency, which are obtained by the participant, without cost to him, by compliance with laws or regulations (including Workmen's Compensation Statutes) enacted by any federal, state, municipal, or other governmental body.
2. Plastic operations performed for cosmetic or beautifying purposes.
3. Dental services.

When Does Maternity Coverage Begin? When Does it End?

Maternity coverage is never included on individual contracts or on non-group family contracts.

On all ordinary contracts (Standard Group, Group Conversion or Surgical-Maternity Contracts) the maternity coverage begins when a *family* contract has been in effect for nine consecutive months. By meeting special requirements the nine-month waiting period may be waived for certain groups. In this case immediate maternity coverage is provided. If the physician wishes to find out whether a waiver is in force in a specific case, he may check the patient's policy or write to the Blue Shield office in Madison for information. On all contracts maternity coverage ends when the contract is cancelled for any reason.

Is Dental Service Covered?

No. The Blue Shield contract excludes dental service even if performed by a physician and surgeon. Blue Shield can only provide benefits for services rendered by a physician and surgeon licensed by the State Board of Medical Examiners.

Questions to be Answered Next Month

1. Is gross or net income used to figure the subscriber's income?
2. Tips for prompt payment.
3. How to determine the patient's eligibility for full payment.
4. What are the different contracts issued by Blue Shield?
5. What is meant by "usual case"?

. . . . THE PRESIDENT'S PAGE . . . .

Loan Fund to Assist Medical Students

IN OCTOBER 1950 the House of Delegates authorized the establishment of a loan fund by the State Medical Society. I believe that we should be able to raise the money not only from the doctors themselves but from other persons in the state who are beginning to show an interest in this proposition.

I believe that from the small rural high schools we should endeavor to interest students in the study of medicine. I believe it would be much easier to induce this class of people to go back into the country to practice medicine.

The management of this fund should be entrusted to a board of trustees with definite instructions as to how this money is to be loaned out, when and how it is to be returned, and the board should be so appointed that there is a continuous continuity of membership.

In addition, I believe we should try to encourage young men to locate in groups of two or three. It is hard to get young men to go into the rural communities and practice by themselves, because of lack of facilities. They need modern equipment in order to practice medicine as they have been taught. I refer particularly to the x-ray, microscope, and many other items of like nature that are necessary for the modern practice of medicine. If they were located in groups of two or more, there would be some chance for recreation, some chance for postgraduate study, and there would be a much better chance to furnish around-the-clock medical service in the community in which they are located. A group of this nature could utilize the same equipment that would be necessary for a man if he were alone. With our modern roads and automobile transportation, we do not need a doctor at every hamlet and every crossroad, but we do need small clinics of this nature in certain parts of the state.

H. H. Christofferson M.D.

The Implications of Cash Disability Programs

WHEN a person is injured or becomes ill on his own time away from work, he is immediately confronted with the question of what will happen to his income while he is laid up. Workmen's compensation protects him only for disabilities incurred in the course of his work. Various types of health insurance will meet or help to meet his hospital, medical, and surgical expenses if he has any, but do not replace his income.

If he is unemployed and drawing unemployment compensation, he faces a situation which is particularly difficult to understand. Since he is no longer available for work, he fails to meet the test of unemployment and his benefits are cut off.

In Wisconsin, as in most other states, a working man, therefore, faces a risk of losing his income through disabilities happening away from the job unless he is protected by some type of voluntary disability benefit plan.

Labor leaders and various social planners looking at this situation contend that society has a responsibility to minimize the hardship workers face when disabled off the job and so insist that all employers should be compelled by law to assure weekly or monthly benefits to their employes who are injured or become sick away from work.

Four states have accepted this philosophy and made such coverage compulsory. Washington, a fifth state, passed such legislation but placed it before a referendum of the voters, and in the November 1950 election the voters rejected the plan by a margin of three to one.

In three of the states, the laws have now been in operation long enough to develop some experience. Rhode Island was the first state to enact such a law. It did so in 1942. It has what is known as a monopolistic state fund, which means that employers must take the required coverage from the state fund and not from any other source such as private insurance.

The Rhode Island law provides the same scale of benefits as its unemployment compensation program. It requires a one week waiting period in each benefit year and allows maximum benefits of $25 per week for 26 weeks. Maternity benefits up to 15 weeks are provided. As is possible in such programs, there is sometimes duplication with workmen's compensation benefits, and the Rhode Island law permits such duplication up to 85 per cent of the worker's average weekly wage.

The Rhode Island program is supported by a tax on employes of 1 per cent of their first $3,000 of average wages. There are no contributions by employers.

California, the next state to enact disability benefits law, embarked upon its program in 1946. It is also operated as an integral part of the unemployment compensation law. Coverage is compulsory on employers, but may be provided either through a state fund or by private plans, providing such plans exceed state fund standards.

Benefits are computed on the same basis as unemployment compensation. The maximum is $25 per week for 26 weeks. The waiting period before benefits begin is one week. No maternity benefits are provided and no duplication with workmen's compensation benefits is permitted. Through recent legislation, provision is made for payment of an additional $8 per day for each day of hospital confinement up to 12 days, in which case the waiting period mentioned above is also waived. Most favorably considered, this looks like a mixing of time loss and hospital benefits. It may also indicate a design to convert this program into a health plan.

The California disability benefits tax applies to workers only and is 1 per cent of the first $3,000 of annual wage. Prior to enactment of its disability benefits program, California was one of the states that taxed workers for unemployment compensation. The existence of this tax on employes' wages was an important factor in California's decision to embark upon this program. As a result of action of Congress in 1946, California was authorized to use over $300,000,000 of such accumulated taxes for its disability program.

New Jersey, a third state with a compulsory program, passed its law in 1948. Benefits again are computed as under unemployment compensation. The maximum weekly benefits are $26 per week for 26 weeks. There are no maternity benefits, and no duplication of benefits with workmen's compensation is permitted. Like the other two states, the waiting period is one week.

Similar to California, the New Jersey plan provides a competitive state fund. Coverage in this fund is automatic unless a private plan is chosen equaling or exceeding state fund standards.

Employes contribute ¾ per cent of their first $3,000 of annual wages for this program and employers ¼ per cent of the first $3,000 of wages if they are in the state fund. If not in the state fund, they provide the balance of the cost of their private plan. As in the other two states, an existing tax on employes for unemployment compensation was an incentive in the adoption of the New Jersey law. Fifty million dollars of the funds made available as a result of the action of Congress in 1946 were withdrawn to start the New Jersey program.

New York was the most recent state to pass a compulsory law, approving its plan in 1949. Unlike the other states, its program is an extension of workmen's compensation rather than unemployment compensation. There is no tax-supported state fund, but the state provides competitive insurance

for employers who choose it in preference to private plans.

Benefits are computed at one half average weekly wages, the maximum being $26 per week for 13 weeks. There are no maternity benefits, and no duplication with workmen's compensation is permitted. The waiting period as in the other states is one week.

Employes pay ½ per cent of the first $60 of weekly wages, and the employer pays the balance.

Looking at the experience of these plans, there are serious shortcomings in all of them. The Rhode Island law is bad because it sets up an exclusive state fund in a field where private enterprise has already demonstrated ability to function effectively. It has not answered the demands of labor, which has insisted on retaining what it already had plus the benefits of the new law as well.

The competitive state funds in California and New Jersey are undesirable because there are hidden subsidies to these state funds with which all insurance companies must compete. It is basically wrong to have the people administering the state funds also administer the private plan portion of the program. The New York law is widely heralded as the best of such compulsory insurance laws, but its support is still largely on theoretical grounds, since benefits have been payable only since July 1, 1950.

Many individuals and groups have opposed compulsory cash disability benefit laws upon the basic principle that such laws are incompatible with the principles of freedom and individual rights upon which this nation is founded. They believe that it denies the individual his freedom of initiative, responsibility, and the rewards of thrift.

While these states have turned to compulsory laws, other states, including Wisconsin, have relied on voluntary plans to fill this need. Voluntary plans are of several types. They include group insurance (provided through employers, unions, associations, or other groups), formal sick benefit plans where the employer provides benefits without insurance, employe benefit associations where workers get together and provide their own benefits through their own dues structure, fraternal organization benefits provided through their own funds, and individual insurance.

No comprehensive survey of total coverage in Wisconsin has ever been made. The Industrial Commission of Wisconsin in 1948 analyzed coverage among employes covered by unemployment compensation which applies to employers of six or more workers. It found that about 338,000 workers, or 47 per cent of those covered under unemployment compensation, were protected by some type of disability benefits program at the source of employment.

This study did not attempt to tabulate those covered by individual insurance or those covered by informal employer plans on which data could not be readily supplied.

Since then, the Survey Committee of the Health Insurance Council has come forth with some national figures which have given an important clue at least to total coverage in Wisconsin. Nationally, the study of the Council shows that in 1949 about 34,000,000 persons had some voluntary plan giving them protection against loss of income due to disability.

Using the figures supplied in this study for group insurance and individual insurance and estimating Wisconsin's share of this coverage from its proportion of national health and accident written in 1949, then adding persons covered under other types of plans from the Industrial Commission's 1948 study, it is estimated that roughly 700,000 were protected under voluntary plans in Wisconsin in 1949.

This, incidentally, is about the same number of persons who would be covered under a compulsory law extending to employers of six or more workers.

One of the important questions in connection with voluntary plans is their cost. The cheapest types of voluntary protection and the one written with the least qualifying restrictions is group insurance. This type of insurance is available to several types of groups including unions in certain instances, but most commonly it is written in the plant with the employer's cooperation and financial participation.

The cost of this insurance is frequently quoted as so much per month for each $10 of weekly indemnity. Groups with a high percentage of female workers are known to require higher benefit payments, so the rates usually increase with the percentage of women covered.

Under a typical policy where benefits become payable after one week of disability with a duration of 26 weeks where the percentage of women is less than 11 per cent of the total group, the premium for benefits of $25 per week would be $.46 per week. The same benefits where the group was 61 to 71 per cent women, the monthly premium would be $.76.

Group plans are written on larger numbers of employes, usually 25 or more, and in order to make the coverage possible, a frequent requirement is that at least 75 per cent of the workers must come under the plan. This requirement is necessary to assure that there will be persons who are good risks along with the poorer ones.

For smaller groups, franchise insurance is available. This is a little more expensive than group insurance, but can be written without excluding existing disabilities. Again, a certain portion of the eligible workers, usually about three-fourths, is required in order to secure the plan.

A typical policy of this type written on men providing benefits of $100 per month for 52 weeks with partial benefits at 40 per cent of the full rate and with a waiting period of one day for accidents and one week for sickness requires a monthly premium of $3.25.

For those who are not members of a group covered by any type of plan, individual insurance is

available. According to the Survey Committee of the Health Insurance Council, more persons are protected under such policies than under any other plan or type of insurance. Nationally, about 13,700,000 persons had individual insurance in 1949 while about 10,300,000 were covered under group insurance. Approximately another 12,000,000 employes are insured for disability benefits by other types of coverage, such as Mutual Benefits Associations, paid sick leaves and union plans. There is an estimated duplication of coverage of about 2,000,000 persons. The over-all coverage, therefore, would amount to over 34,000,000.

Generally speaking, individual insurance plans provide benefits for a longer duration than group or franchise plans. Usually, individual policies are written for at least a year's duration up to lifetime coverage in the case of accidents. These policies are available to self-employed persons as well as wage-earners. Because of this, care must be taken in trying to compare costs of certain of these policies with others not providing protection for occupational hazards.

A typical policy for men under 50, providing $100 monthly benefits, paying from the first day in the case of accidents up to 52 weeks and from the eighth day in the case of sickness up to 26 weeks, costs $2.25 per month. This same policy for men from age 50 to 60 costs $3.37 per month.

The greatest criticism of individual policies is that preexisting disabilities may require the company writing the insurance to exclude benefits for certain existing disabilities, or disabilities which have a strong possibility of recurring on the basis of the person's medical history. Such waivers are necessary if the company and its policyholders are to avoid large losses on disabilities which are almost certain to recur.

Certain illnesses and injuries may also result in the outright denial of insurance of any type. Different insurance carriers have different policies in such cases. However, it appears that outright rejection rate for most companies is relatively low. Typical companies writing individual insurance indicated that their rejection rate—i.e., denial of any type of loss of income coverage because of unfavorable medical history—is less than 5 per cent of those applying for coverage.

Another criticism of individual policies is that they are frequently limited to persons under 65 years of age. While this is usually the case, there are now companies writing such business in Wisconsin for persons over age 65. It is also commonly the policy of many companies that persons who carry such insurance prior to age 65 may continue to carry it after that age. Insurance companies appear to be making rapid strides in the extension of coverage to older age persons and to those with serious existing disabilities, so that basis of criticism of individual plans would seem to be lessening as time goes on.

One characteristic of voluntary disability plans is the great variety of plans available and the large number of insurance carriers writing the coverage. Those who would like to see all workers forced into a uniform program criticize this flexibility. One of the great advantages of voluntary plans for both employers and workers is that they have the opportunity to select plans which best fit their particular needs.

To fill the variety of demands for different types of coverage, some 85 companies are licensed to write this type of insurance in Wisconsin. This, of course, means that there are costs in selling the insurance, and each policyholder pays in his premium a share of the selling costs, but the element of competition acts as the automatic regulator to prevent any company from getting much out of line on its selling and administrative costs. These same selling and acquisition costs would exist under any compulsory program except in the case of a state monopoly such as Rhode Island. In such cases, without the element of competition, the administrative costs of a state monopoly must either be studied and challenged when necessary or accepted without question.

To date, Wisconsin has rejected any type of compulsory law, and by relying upon voluntary plans has profited by the continuous growth in coverage and improvement in benefits.

In the 1949 session of the Legislature, three bills proposing compulsory insurance were introduced and defeated. Similar legislation will very likely be offered in the 1951 Legislature. Wisconsin citizens exercising their right of petition to legislative representatives have an important decision to make—whether Wisconsin is to continue its program of voluntary action in this field or embark upon a new program of government compulsion and regulation.

Income Tax Provisions Affecting the Medical Profession

I. FEDERAL

Introductory

THE subject of federal income taxes continues to be increasingly complicated and technical. It cannot be simplified beyond a certain point. A physician will ordinarily find it economical, from the standpoint of time and money to turn income tax matters over to his attorney or accountant, so that he may concentrate in his own professional field.

No effort has been made in this article to consider the special problems which arise in medical partnerships of two or more physicians, or in connection with the operation of larger units of medical practitioners, including clinics. In the first place, units of that size ordinarily employ an attorney and a consulting accountant. Second, although their problems in the main follow those of individual physicians, and the text which follows is generally applicable to them, certain of their problems, such as the fixing of shares of net income, donations and capital gains, are dependent upon individual agreements, and cannot be treated in a general article of this nature.

The advantages of preparing income tax returns correctly and of taking full advantage of all permissible deductions and exemptions are at least twofold. One is the saving of the physician's time. It is costly for him to have to submit needlessly to interrogation, by interview, letter, or audit. Second is the reduction in taxes, and the saving of possible later penalties and interest which come from the proper preparation of returns.

Those who desire more detailed information than is possible in a short general article of this type will find the following helpful: "Physicians Federal Income Tax Guide," by Campbell and Liberman, 1951 edition, published by Doniger & Raughley, Inc., Great Neck, New York, price $2.50. Also helpful as soon as the 1951 edition is available is "Your Federal Income Tax," which may be ordered from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., price 25 cents. The informational pamphlet which can be obtained from your post office or from the Collector of Internal Revenue at Milwaukee or Madison about the middle of December should also prove helpful, although it is less detailed than either of the other two.

1950 Revenue Act Changes

Summary

On September 23, 1950, the federal Revenue Act of 1950 became law. As originally drafted, the bill was intended to clarify, to close tax loopholes, and to reduce certain excise taxes. After the Korean War began, the bill was revised to provide additional income tax revenue.

The new law increases the tax liability of all individuals whose tax year ends after September 30, 1950. Special rules of computation apply to those whose taxable year began prior to October 1, 1950, but on a date other than January 1, 1950, and whose taxable year had not ended on September 30, 1950.

Normal and surtax rates used in computing the total tentative tax are not changed by the new law. However, the percentage reductions allowed under the 1948 Revenue Act will be reduced about one-fourth on 1950 returns and entirely removed on 1951 returns. The effect of these changes is to increase tax rates from 1 to 3 points in 1950, and from 2 to 8 points in 1951, depending on the bracket into which the taxpayer falls.

The arithmetical effects on individual returns of the 1950–1951 rate changes, by comparison with those of 1949, may be thus summarized:

First compute the tentative tax and surtax. Then for:

(1) Taxable years beginning before October 1, 1950 (other than the calendar year 1950), the tentative tax is reduced as follows:
- 17 per cent of the first $400 of tentative tax;
- 12 per cent of that part of the tentative tax in excess of $400 and not in excess of $100,000;
- 9.75 per cent of that part of the tentative tax in excess of $100,000.

(2) 1950 calendar year, the tentative tax is reduced as follows:
- 13 per cent of the first $400 of tentative tax;
- 9 per cent of that part of the tentative tax in excess of $400 and not in excess of $100,000;
- 7.3 per cent of that part of the tentative tax in excess of $100,000.

(3) 1951 calendar year, and other taxable years beginning after September 30, 1950, **No percentage reduction is allowed.**

It should be emphasized that in other basic respects, the 1950 Revenue Act follows the pattern with which physicians have become familiar during the past several years. Exemptions are unchanged, as are standard deductions, and the privilege of split income, as between husband and wife. The latter continues to be an effective means of reducing tax liability in all but a small number of cases.

Armed Forces Income

Withholding of otherwise taxable income, under brackets also revised by the 1950 Revenue Act, is required at the new rate of 18 per cent for active service in the armed forces of the United States subsequent to December 31, 1950, with the follow-

ing exception: any month between November 1, 1950 and January 1, 1952, during any part of which such person served in a combat zone as defined by the President.

The *first* $200 of monthly compensation received by a commissioned officer for active duty in the armed forces of the United States for any month, during any part of which he served in a combat zone, such as Korea, is exempt from federal income tax. Such month must have begun after June 24, 1950, and must have ended before January 1, 1952 under the current law.

Dividend Income

The 1950 Revenue Act continues to require investors to report taxable dividends in gross income on line 3, page 1. This would include all ordinary cash dividends and all taxable stock dividends. The determination of what is a taxable stock dividend is a technical legal question to be determined by an attorney. There are at least five types of corporate dividends which are *not* taxable. The physician should carefully furnish *all* dividend data to his tax consultant for determination of the question of taxability.

The reason for emphasizing dividends in the preceding paragraph is that the 1950 Revenue Act requires for the first time that taxable dividends be itemized in new Schedule "A" at the top of page 2 of form 1040. The Act also requires for the first time that a corporation report the names of *all* recipients of dividends, no matter how small the amount. The physician will save himself much time and effort by reporting accurately on his return all taxable dividends received.

Higher Tax Rates in 1951

Earlier in this summary of highlights of the 1950 Revenue Act, it was shown that individual rates increase 1 to 3 points in 1950, and 2 to 8 points in 1951. It is very likely that sometime prior to the close of 1951 Congress will raise rates further. The best present opinion is that such increases will average 3 points. Thus, a 22 per cent bracket would become 25 per cent, and so on.

These greatly increased tax revenues are necessitated by rearmament costs. The taxpayer would do well to assume that high rates will remain in effect indefinitely. It is thus in the direct financial interest of every physician to keep complete records of every transaction, no matter how small, which has known or possible income tax implications.

General

Split Family Income. The purpose of the split family income provisions of the 1948 Act, which was not changed by the 1950 Revenue Act, was to equalize the tax burdens of married couples in community property and common law states. Under the statutes of about a dozen states it has hitherto been possible for a wife to return one-half the income, even though in point of fact she may have received none of it from her personal services or invested earnings. This was under the so-called "community property" rule. This placed husband and wife at a corresponding tax disadvantage in the other three-fourths of the states which did not have such a rule. This disadvantage had increased significance as income tax rates were raised and became more steeply progressive.

Income splitting provision permits return of all income of the husband and wife on a joint return. It also permits a husband to join with his wife, or a wife with her husband, on a joint return even though one of the spouses had no personal income. The new rates are so devised that where such a joint return is filed by husband and wife it is, in effect, taxed as if one-half of such income belonged to each spouse. The tax reduction in such cases results from using the lower brackets of surtax rates twice, instead of computing one tax at progressively higher rates.

Who May File a Joint Return. The split income tax feature of the 1948 Act is limited to spouses who live together and have the same tax year. Divorced or legally separated persons may not file such returns. Should one spouse die during the year who had the same tax year as the survivor, the survivor and the deceased spouse's estate may file a joint return and enjoy the advantages thereof as though both had lived. The new law permits husband and wife to file a joint return even though one of them has no gross income or deductions.

When A Joint Return Is Advisable. It should be noted first that the filing of a joint return is optional just as it was in prior years. Formerly it was advantageous for married persons to file jointly only in the rare case where the tax on the combined income was lower than on the separate returns. This resulted usually from deductions and losses from one spouse which could not be fully offset against that person's income. Under the 1948 law, the filing of a joint return usually reduces the total tax.

In almost all cases in which husband and wife have a combined net income over $2,000.00, after deductions and exemptions, it will be advantageous to file a joint return. One exception would be where both spouses have substantially the same net income. A second exception might arise where 5 per cent of the combined incomes would be insufficient to cover the medical expenses of both spouses, although maximum advantage might be enjoyed on separate returns. This situation will rarely exist, however.

Where each spouse has taxable sales or exchanges of property, it may not be advantageous to file a joint return despite the income-splitting provisions. The only way to be sure whether a joint or separate return is more advantageous is to compute the tax both ways where the above exceptions appear.

Mechanics Of Joint Return. No purpose would be served here by setting out the mechanics of the joint return under the 1948 Act. Suffice it to say that after determining net income less exemptions, the

resulting figure is divided in half, the tentative normal tax and surtax is computed on such half, such computation is further reduced by the 1950 specific reductions in rates, and the resulting tax liability so determined is multiplied by two.

Obviously, if a physician had a net income for 1950 of $15,000.00 and can cut it in half for tax purposes, the resulting taxes on two $7,500.00 incomes is less than the tax on a single $15,000.00 net income because of the graduated rates.

It should be remembered that the signatures of *both* spouses is required on joint returns. *Each* spouse is jointly liable with the other and also individually liable for part or all of the tax, as the government may elect. Thus, the government could collect the tax from the spouse who had enjoyed none of the income, so long as the latter had signed the return. Also, once a joint return is filed for a given year, neither party may seek to revoke the joint return by filing an individual return. The choice may be made each year, however. In the absence of fraud, unless the gross income has been understated by 25 per cent or more, or unless the taxpayer waives the statute of limitations, the federal government is precluded from assessing a taxpayer after the lapse of three years following the filing of a return, even though such taxpayer had no income in the year for which a return was filed, provided such return was filed on time. This is a further advantage of the joint return.

The federal government provides the following three types of personal income tax returns: Short-Form 1040, Form 1040A, and Long-Form 1040. In some cases no choice is open to the taxpayer in selecting a particular form over others. There are situations in which a choice is open, however, as appears from the text following.

The paragraphs following are taken from a pamphlet distributed by the United States Treasury in connection with the preparation of 1948 returns. Its language is simple, helpful, and applicable to the making of 1950 returns.

Income Less Than $5,000. 1. *Form 1040A.*—This is the simplest return of the three. It is similar to the form which appeared last year on the back of a Withholding Statement. If you file this form, you do not need to figure your own tax. From your answers to the questions, the Collector will figure your tax for you, and send you a bill or a refund. If your total income was less than $5,000 and consisted entirely of wages reported on Withholding Statements (Forms W–2), or of such wages and not more than $100 total of other wages, dividends, and interest, you may use Employee's Optional Income Tax Return (Form 1040A). If you had any income from other sources, such as annuities, rents, royalties, a business or profession, farming, transactions in securities or other property, partnerships, estates, and trusts, you may not use Form 1040A but must file your return on Form 1040. You cannot deduct travel or reimbursed expenses from your wages if you file from 1040A.

2. *Short-Form 1040.*—Form 1040 may be used either as a short form or as a long form. The short form is simpler than the long form. It differs from Form 1040A in that (a) you must find your own tax; (b) you may include income from sources not eligible for Form 1040A; and (c) you may deduct travel and reimbursed expenses from your wages. Therefore, if your income was less than $5,000 and you do not desire to itemize nonbusiness deductions (contributions, interest, etc.), find your tax from the table on the back of the form, tear off the first sheet and file it as a short form.

3. *Long-Form 1040.*—If your nonbusiness deductions are more than 10 percent of your income, you will ordinarily save money by itemizing your deductions on Long-Form 1040. You will then figure your tax according to the computation on page 3, and file the entire form, which is called a long-form return. If your nonbusiness deductions are so close to 10 percent that you are in doubt which is the better form, try both the short form and the long form to make sure.

Income of $5,000 or More.—If your income was $5,000 or more, you must use Long-Form 1040. However, in that case, you can either take a standard deduction or itemize and claim your actual deductions. You should compare your actual deductions with the amount the standard deduction allows you. If actual deductions exceed the standard deduction, you will save tax by electing to itemize them. If you are single, or if you are married and file a joint return, the standard deduction is 10 percent of your income but not more than $1,000. If husband and wife file separate returns, the standard deduction is a flat $500 for each.

Personal Exemptions. Personal exemptions and credits were raised from $500.00 to $600.00 each by the 1948 Act. It should be noted that in the case of dependents the credit allowed the tax payer is $600.00 but it may be taken only for dependents whose income is less than $500.00. No credit for a dependent may be taken where the latter has filed a joint return with a spouse. In such case a personal exemption can be taken by the filing dependent.

A special exemption of $600.00 for each tax payer over sixty-five is permitted, in addition to the ordinary personal exemption of such person. The Act also allows an *additional* exemption of $600.00 if the tax payer's spouse is over sixty-five, or attains such age during the year, provided such spouse has no gross income and is not the dependent of another tax payer.

The former special exemption of $500.00 for the blind has been increased to $600.00. This is available to tax payer and his spouse. It should be noted that where a person is over sixty-five, or is blind, and is a dependent of a tax payer other than a spouse, no additional exemption is allowed such tax payer. As an example, a husband whose wife is over sixty-five, blind, and dependent upon him for support, may

claim a triple exemption of $1,800.00 for such wife. If a son were supporting the wife instead of the husband, and the fact were otherwise the same, the son could claim only $600.00 exemption for his mother.

Medical Expenses. The 1948 Act did not change the earlier rule that only those medical expenses in excess of 5 per cent of the tax payer's adjusted gross income may be deducted. The new law did raise the ceiling amounts allowable, however. On a separate return no more than $2,500.00 may be deducted for medical expenses. On a joint return as much as $5,000.00 may be deducted. The maximum allowances will be summarized in the following table.

Joint Return	Maximum Allowable
Husband and wife	$2,500
Husband and wife and one other exemption	3,750
Husband and wife and two or more other exemptions	5,000
Separate Return	
One exemption	$1,250
Two or more exemptions	2,500

For further treatment of this subject see page 1159 of this article.

Alternative Tax. If there is an excess of combined net long-term capital gains over combined net short-term capital losses on a joint return the law provides an alternative method for computing the tax. Every dollar of such excess is taxed at a 50 per cent rate, and in some situations this may be lower than the tax regularly computed on form 1040.

Under the 1948 Act use of the alternative method will never result in a tax liability lower than that regularly computed on form 1040 unless the combined net income and capital gains of husband and wife who make a joint return, exceeds $44,000.00. The same statement would hold of an individual making a separate return on a net income plus capital gains of $22,000.00 or over.

These two figures are only turning points, and the computations must be made by competent people who will know whether the alternative tax increases or decreases the total tax liability.

For further consideration of this question see the subsection of this article beginning on page 1155 entitled "Capital Gains and Losses."

Individual Federal Income Tax Calendar 1951

15th of each month (except January, April, July and October). Pay income taxes withheld on wages to a government depository if more than $100 in combined withohlding and social security taxes (entire 3 per cent) was withheld during the previous calendar month. If $100 or less is withheld in a month, no payment for such month need be made until the quarterly return is filed on or before January 31, April 30, July 31, and October 31.

January 15. Pay final installment of estimated 1950 tax. Also final date for amending 1950 declaration of income or filing a final return in lieu thereof. If a 1950 income tax return is filed by this date, it may incorporate any previous underestimate of 1950 income, and no penalty which would otherwise be imposed for underestimating such income will have to be paid if the full balance of the 1950 tax is forwarded with the return.

January 31. Due date of employer's return of income tax withheld and Social Security tax for last quarter of 1950. Also deadline for withholding and Social Security tax payments. The employer must furnish to each employe whose wages exceed the amount of one withholding exemption during 1950, a written statement, Form W–2, showing the wages paid during 1950 and the amount of tax withheld on such wages.

February 15. Due date of information returns showing interest or rent payments of $600.00 or more, and wage payments of that amount not subject to withholding.

March 15. The following are due on or before this date:

(1) Due date of individual income tax return for 1950, for those whose tax year ends December 31, 1950, unless made on January 15. Any excess of tax shown on this return over tax withheld and amounts paid on tax during 1950 is due on this date.

(2) Declaration of Estimated Tax for 1951; one quarter of estimated tax payable on this date.

(3) 1950 partnership and corporation income tax returns where the income tax year ends December 31, 1950.

(4) Gift tax return; and any gift tax due thereon.

April 30. Due date of employer's returns of income tax withheld and Social Security tax for first quarter of 1951. Also deadline for withholding and Social Security tax payments to accompany returns.

June 15. Due date of second installment of estimated 1951 tax; date for filing Declaration of Estimated Tax where requirements were first met between March 1 and June 2. Amendment of Estimate previously made may be filed at this time.

July 31. Due date of employer's return of income tax withheld and Social Security tax for second quarter of 1951. Also deadline for withholding and Social Security tax payments to accompany returns.

September 15. Due date of third installment of estimated 1951 tax; date for filing Declaration of Estimated Tax where requirements were not met until a date between June 1 and September 2. Amendment of Estimate previously made may be filed at this time.

October 31. Due date of employer's return of income tax withheld and Social Security tax for the third quarter of 1951. Also deadline for withholding and Social Security tax payments to accompany returns.

1952

January 15. Pay final installment of estimated 1951 tax. Final date for amending 1951 declaration of income, unless taxpayer prefers to file his 1951 income tax return by that date.

Withholding Taxes and Declaration of Estimated Tax

Employers Require to Withhold. Every physician employing persons for wages which are subject to the withholding tax must withhold from such wage payments an amount computed in accordance with the formula or tables provided by the Commissioner of Internal Revenue upon request. The amount so withheld must be paid by the fifteenth of the following month to a government depository (a designated bank) if a total of more than $100 in combined withholding and social security taxes (entire 3 per cent) was withheld from all employees during the previous calendar month. If $100 or less is withheld in a month, no payment for such month need be made until the quarterly return of taxes withheld is filed on or before January 31, April 30, July 31, and October 31.

Physicians should obtain from each employe an Exemption Certificate Form W–4 duly signed by the employe. This form should be obtained at the time employment begins. An amended form should be signed and filed with the employer whenever the latter's exemption status changes. If no certificate is furnished the employer, no exemption is allowed in computing the amount of tax to be withheld.

Wages Subject to Withholding—Exceptions. Wages subject to withholding include all remuneration paid to an employe, whether designated as salary, wages, fees, commissions, et cetera, and whether paid in cash or in something other than cash. All wages *paid* after October 1, 1950, irrespective of *when* earned, are subject to the higher withholding rate of 18 per cent established by the 1950 Revenue Act.

Excluded from "wages" and not subject to withholding are the following:

(1) Fees paid to public officials, such as notaries public and sheriffs.

(2) Compensation for services as a member of the military or naval forces of the United States through 1950.

(3) Remuneration for agricultural labor.

(4) Payments for domestic service in a private home or college club or a local chapter of a college fraternity or sorority.

(5) Compensation for casual labor not in the course of employer's trade or business.

(6) Remuneration for services rendered as a minister.

Statement of Taxes Withheld. For 1947, and thereafter, the employer must furnish each employe in duplicate, with Form W–2, showing the amount of taxes withheld from his pay, even though no tax is deducted, if the wages paid to the employe exceed the amount of one withholding exemption as shown by the federal tables.

Filing Declaration of Estimated Taxes. Every physician must file a declaration of his estimated 1951 federal income taxes if:

(1) His gross income not subject to withholding tax is expected to exceed $100, and his gross income will be $600 or more.

(2) His gross income from wages subject to withholding can reasonably be expected to exceed $4,500 plus $600 for each exemption in addition to his own.

This estimate must be filed by March 15, 1951 and amended estimates may be filed on June 15, September 15, and January 15 following.

A husband and wife living together may file a single declaration on which they will be jointly liable.

Penalties. Penalties are provided for failure to file Declaration of Estimated Tax and failure to pay installments when required to do so.

For underestimating tax by more than 20 per cent (33⅓ per cent for farmers).—Six per cent of entire shortage in estimate, but not more than the amount by which the estimate falls short of 80 per cent of the tax (or, in the case of farmers, 66⅔ per cent of the tax).

This penalty will not apply if (*a*) the estimated tax is computed on last year's income at this year's rates and exemptions, and is paid on time in equal quarterly installments, or (*b*) is paid ahead of time, or (*c*) if an income tax return is filed and the full balance of the tax paid on or before January 15 of the succeeding year.

Summary of Applicable Provisions

Effort is made in this portion of the article to summarize for the assistance of physicians, or their office staffs, those provisions of the federal income tax law which most commonly apply to a medical practitioner and to operation of a medical office. No claim is made that the treatment is exhaustive. It is only a partial outline, but inasmuch as professional assistance would be required for more technical matters, it might prove confusing to go into any fuller detail than has been attempted here.

General Instructions. Income tax returns for all taxpayers reporting on a calendar year basis must be made to the Collector of Internal Revenue, Milwaukee, not later than March 15, 1951. An extension of time up to six months for filing a return can be had for reasonable cause. Application for extension should be filed with the Collector of Internal Revenue on form 1134, prior to March 15.

Responsibility for making all returns is in the individual. Liability to make a return depends not on whether one has a tax to pay but on the amount of his reportable income.

Dependents; Wife. Under the law as changed in 1944, the age of the dependent or his ability to support himself is no longer material. A dependent means one of the following persons over half of whose support for the calendar year in which the taxable year of the taxpayer begins was received from the taxpayer:

(a) A son or daughter of the taxpayer or a descendant of either.
(b) A stepson or stepdaughter of the taxpayer.
(c) A brother, sister, stepbrother or stepsister, half-brother or half-sister of the taxpayer.
(d) The father or mother of the taxpayer, or an ancestor of either.
(e) A stepfather or stepmother of the taxpayer.
(f) A son or daughter of a brother or sister of the taxpayer.
(g) A brother or sister of the father or mother of the taxpayer.
(h) A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the taxpayer.

"Brother" and "sister" include a brother or sister by the half blood. A legally adopted child is considered a child by blood.

A taxpayer cannot claim exemption for a niece or nephew by marriage even though he has furnished more than one-half the support of such person or persons, unless his spouse joins in a joint return. To take an example, a husband who furnishes more than one-half the support of a niece or nephew of his wife may claim an exemption for such niece or nephew only if his wife makes a joint return with him. The exemption will be allowed in such case even though the wife did not furnish the support and even though she did not have any taxable income.

The term "dependent" does not include any individual who is citizen or subject of a foreign country unless such individual is a resident of the United States, Canada, or Mexico. Nor does it include a spouse.

No exemption for a dependent is allowed if the dependent's gross income was $500 or more, or if the dependent is married and has made a joint return with his or her spouse for the calendar year in which the taxable year of the taxpayer begins.

The fact that the dependent was not in existence throughout the year is immaterial. Thus, if a child of the taxpayer supported by the taxpayer is born or dies during the taxable year a full exemption is allowable for such child.

In like manner, a taxpayer who is married during the year and claims an exemption for his wife is entitled to a full exemption for her for that year, if at the close of his taxable year (ordinarily December 31) he was still married to such spouse, or, if she died during the tax year, he was married to her on the date of her death.

Compensation for Services of Children. Compensation for services rendered by a child shall be included in the gross income of the child and not in the gross income of the parent. This was a change made by the Individual Income Tax Act of 1944. Under the present law, the child is considered a separate taxpayer subject to the regular requirements as to filing and is entitled to a separate exemption for normal tax and surtax.

The parent or guardian of the child must file the required return where the child is unable to do so. Liability for the tax on compensation earned by the child is placed on the parent if not paid by the child.

Where the gross income of the child for the calendar year is $500 or more the parent is not allowed to consider the child a dependent.

Items Reportable as Income. Broadly speaking, income includes all wealth which comes into the taxpayer's hands, other than as a return of capital. It is not even necessary in all cases that the income be *actually* received before the close of the taxpayer's reporting year for him to be obligated to report receipt of a certain item as income. Thus, salaries or bonuses are sometimes set up in a given year, and are made available to the taxpayer, although not paid to him until after the first of the following year. He would nonetheless have to report such items ordinarily because of the availability of such income to him. This is known technically as "constructive receipt" of income.

The same general rule would hold for dividend checks mailed before the close of the tax year, although not actually received by the taxpayer until a day or two after the first of the following year.

The following items, which have some application to physicians as a group, are reportable as income:

1. Compensation for professional services, whether in the form of salary, personal earnings from the practice of medicine, or the share of profits from a professional partnership between two or more physicians. The salary paid by a branch of government must also be included as income; as must a teaching salary, lecturing fees, and the like. Physicians sometimes have income for personal services of a nonprofessional character such as executor fees for handling an estate, or directors' fees received from a corporation as compensation. Such items are likewise reportable in gross income.

2. Earnings from investments. The most common of these would consist of cash dividends on corporate stock; interest from loans, bank savings, or bonds of business corporations; interest on U.S. savings bonds issued after March 1, 1941; rents from buildings and lands.

3. Income in the form of interest on life insurance proceeds held by the insurance company under an agreement to pay interest is includable in gross income. If a life insurance policy is surrendered by the insured for a lump sum in excess of total net premiums paid, the insured person realizes income to the extent of such excess over his cost.

As to annuities, or a matured endowment policy paid in installments under an option selected by the insured before the endowment matured, 3 per cent of the cost of such annuity or endowment is includable annually in gross income, if that amount or more is received in payments in a particular year. The remainder of the income from either source for a particular year is excluded from gross income. When the aggregate amount excluded equals the cost of the annuity or endowment, the entire

amount received thereafter must be included in gross income.

4. In addition to items strictly classified as "income," one is also obligated to report ordinary gains and losses on the sale of property owned by the taxpayer in addition to capital gains and losses. The latter subject is separately discussed on this page. The subject of gains or losses, and when taxable or deductible as the case may be, is perhaps one of the most technical fields of federal tax law and should be placed in competent hands. Otherwise a tax may be paid needlessly in one instance, and penalties and interest needlessly incurred in another.

5. Income from royalties or from a farm or other business in which a physician is interested apart from his professional practice.

Items Not Reportable as Income. The following items are not required to be reported because exempt from taxation: gifts, bequests, devises and inheritances; damages received on account of personal injuries or sickness, whether paid by an insurance company or as a result of successful litigation; dividends on stock of federal reserve banks, land banks, intermediate credit banks and national farm loan associations; dividends from corporate earnings accumulated prior to March 1, 1913; amounts received through health, accident or workmen's compensation insurance, and damages received by the taxpayer for illness or injuries suffered by him; life insurance proceeds paid by reason of death of the insured (where a policy matures during life the amount of the proceeds, in excess of the net premiums paid, is taxable income).

Also, corporate stock dividends of the same kind as previously held by the taxpayer in the issuing company; payments to war veterans under the Adjusted Compensation Payment Act of 1936; earned income received from sources without the United States by a citizen who is a bona fide non-resident for the entire taxable year except amounts paid by the United States or any agency thereof; pensions and compensation received by veterans from the United States, and pensions received from the United States by the family of a veteran for services rendered by the veteran to the United States in wartime.

Interest on obligations of a state or political subdivision thereof is excluded from taxation.

Partially tax-exempt interest on government obligations includes the following:

(1) Interest on the excess over $5,000 of United States Savings bonds (at cost) and Treasury bonds (at face value) issued before March 1, 1941.

(2) Interest on obligations of instrumentalities of the United States issued prior to March 1, 1941 (except Federal land banks, Federal intermediate credit banks, and joint-stock land banks).

(3) Dividends on share accounts in Federal savings and loan associations if the shares were issued prior to March 28, 1942.

Capital Gains and Losses. Capital gains and losses are now classified as follows:

(1) *Short-term* capital gains and losses are those resulting from the sale or exchange of capital assets held not more than six months.

(2) *Long-term* capital gains and losses are those resulting from the sale or exchange of capital assets held more than six months.

One hundred per cent of the gain or loss is recognized on short-term transactions, and 50 per cent of the gain or loss on long-term transactions. After applying the proper percentages of gains and losses, both short-term and long-term are treated together.

It is important to note that a net capital loss is deductible against ordinary income only to the extent of $1,000. The portion of the net capital loss which is disallowed, because it exceeds $1,000 in a given year, may be carried over to the five succeeding years to be applied against any future capital gains and also against other ordinary income up to the $1,000 maximum in each such future year.

The alternative tax has been continued in so far as a net long-term capital gain, after reduction for any net short-term capital loss, is concerned. There is, however, no longer any alternative tax in the case of a long-term net capital loss. The rate has been increased from 30 per cent to 50 per cent, but since the rate applies to only 50 per cent of the actual gain, this represents an increase in the effective rate only from 15 to 25 per cent.

The entire gain or loss from a sale of improved business real estate held less than six months is now treated as an ordinary gain or loss, with 100 per cent recognition for income tax purposes. It is treated as a capital gain, if the property was held more than six months. In such latter cases only 50 per cent of the gain is subject to tax, but in case of a loss, the entire amount thereof is deductible.

If any securities issued by any corporation, including stocks, rights, bonds, debentures and other evidences of corporate indebtedness, are ascertained to be worthless and are charged off within the taxable year, the loss resulting therefrom shall be considered as a loss from the sale or exchange of capital assets *as of the close of the taxable year.*

Individuals not involved in the sale or exchange of any capital or other assets during 1950 need have no concern over these capital gains or losses provisions.

Special Rule on Accounts Receivable

Certain types of taxpayers, including physicians, are permitted by the federal act to report income on a *cash* as distinguished from an *accrual* or due basis. This is in recognition of the fact that much taxable income is not received by certain business and professional men until long after the tax period in which the right to receive such income accrued. This is notably true of accounts receivable, and also of notes receivable, rent and interest receivable.

Example: A physician charges his patients a total of $25,000 on his accounts receivable records in a

given year, but collects only $15,000 of it in cash during that year. He also collects in cash during that same year the further sum of $5,000 in payment of services rendered by him to patients in prior tax years. His gross *cash* income for that year is thus $20,000, while his gross income on an *accrual* basis is $25,000.

Generally speaking, it is advantageous from a tax standpoint for a physician to report and pay only what is *actually received* in accounts, notes, interest, rent and similar items, because his losses from these sources are so much higher than those of a commercial concern. Physicians recognize this fact from experience, and almost universally report on the cash basis.

In 1934, however, a provision was added to the revenue act which required that upon the death of a taxpayer a valuation should be placed on *all accounts* and other receivables which were uncollected at the time of such taxpayer's death, and that such valuation was to be *added* to the taxpayer's cash income in the year of death, although *none* of such accounts were in fact collected until subsequent to such death. The effect of this statute was to put on an accrual basis a person who died in the course of a tax year, and who had hitherto been on a cash reporting basis. It had the effect of subjecting to income taxation what was considered the fair valuation of all unpaid accounts due to the taxpayer at the time of his death.

Important Amendment of Accounts Receivable Rule. Without considering the legal basis for the above rule, it clearly worked an increasing hardship on physicians and other professional men, particularly as receivables have mounted during the past decade along with income tax rates. A 1942 amendment changed the above rule by providing that amounts which are accrued only by reason of the death of the taxpayer shall no longer be included in computing the taxable net income for the period in which falls the date of the taxpayer's death.

In other words, it is no longer necessary to accrue *for income tax purposes* and place a valuation upon the accounts and other receivables due on the date of death. One of the serious features of the former rule was that the estate of the physician or other taxpayer affected first had to pay an income tax on uncollected receivables and then had to pay an estate tax upon the same accounts (if the estate was otherwise subject to such latter tax), even though *no cash* was in fact received by the estate from the accounts within the time that the two taxes became due and were paid.

The 1942 amendment above summarized is extremely important to the practicing physician and may mean a substantial saving in taxes to his estate.

It should be emphasized that accounts and other receivables do not by any means escape taxation under the amendment, for such a result would be inequitable from the standpoint of the government. A valuation is still placed upon them, and if the estate is otherwise subject to a federal estate tax the accounts in that sense still pay one tax during the course of probate. The accounts themselves, however, are not treated as income excepting as they are collected, where the deceased person reported his income on a cash basis. At the time of collection such income is taxed to the estate or to the beneficiary of the estate, depending upon the recipient.

The above amendment is a very favorable one to taxpayers particularly at this time. Like all other tax provisions, it is likely to be rather strictly construed by the tax authorities, and will not warrant any relaxation of sound business practices and the keeping of adequate accounting and other records. It is important for the practicing physician to observe the following bookkeeping precautions which may have the effect of reducing his tax liability in a proper and legal manner:

1. Do not have on your books, as receivables, accounts due from patients, notes due from patients, interest from loans or other obligations due you, or rental to which you are entitled from leased property, where such items are of doubtful collectibility or known to be uncollectible. Your estate may have trouble in proving an account is bad and getting an allowance for it, thereby compelling payment of a tax on an account which neither you nor your heirs will ever collect.
2. Write off known bad accounts and notes at least annually, even though you are reporting on a cash basis. If you are reporting on an accrual basis, set up adequate reserves for bad and uncollectible accounts and charge against the reserve all accounts known to be in this classification.
3. Keep in your files such information as your patients and other debtors volunteer, or which you obtain from other sources, which will provide a basis for showing such accounts to be uncollectible, or at least very doubtful.

This rule is limited to the federal income tax, does not affect the state income tax due, and does not involve the valuation of your assets or the computation of taxes due from your estate either to the federal or state governments.

General Deductions

Deductions which will be allowed on the tax return, some of which are peculiar to physicians, are listed below. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail how to arrive at the deductions and depreciation.

With reference to depreciation allowable, the rate of depreciation not only depends on the prospective life of the property when acquired but also on the particular conditions under which the property is used as reflected in the taxpayer's operating policy.

The rates given below are therefore suggestive and tentative rather than final in character.

OPTIONAL STANDARD DEDUCTIONS. Some physicians may find it to their personal advantage to use what is known as a "standard deduction." See page 1151 of this article, right column, under the heading "Income of $5,000 or More."

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Automobiles, 1.
  Depreciation.
  Driver, 1.
  Insurance, 1, 11(b).
  Maintenance.
  Repairs.
Bad debts, 2.
Bandages, 4.
Depreciation.
  Automobiles—20 per cent annually on cost price, 1.
    Classification includes snowmobiles and other motive equipment.
  Instruments, 4.
    10 per cent annually on cost of surgical instruments and general equipment; 10 per cent on cost of x-ray equipment. Rate must be reasonable.
  Medical library, 3.
    10 per cent annually of cost price.
  Office building, 5.
  Office equipment, 5.
    10 per cent annually of cost price (average).
Dues, 7.
Equipment, 4.
  Both long and short-lived.
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Instruments, 4.
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  Automobile, 1.
  Hospital and surgical, 11(f).
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Interest paid 11(h).
Laboratory materials and expenses, 4, 11(c).
Legal expense, 11(a).
Library, 3.
Licenses, 8.
Medical expenses, (personal and family) 11(f).
Medical meetings, 9.
Medical Society group health and accident annual premium, deduct $17—See 11(f).
Medical supplies, 4.
Office expenses, 5.
  Heat, light, supplies, telephones, water, short-lived office equipment, annual depreciation on furnishings and fixtures.
Office rental, 6.
Post graduate studies, 9.
Professional dues, 7.
  American Medical Association.
  County Medical Society.
  State Medical Society.
  Special societies as:
    American College of Surgeons.
    American College of Radiology.
  Any other paid in interest of profession.
Salaries, 10.
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Sales of spectacles, 11(e).
Taxes and licenses, 8.
  Alcohol license.
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  Property (real and personal)
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  Both professional calls and scientific meetings.
Wages and salaries, 1, 10, 11(c).
  Clerk, 10.
  Driver, 1.
  Laboratory assistant, 10, 11(c).
  Maid, 10.
  Nurse, 10.
  Physician, 10.
  Stenographer, 10.
  Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 10.

Explanation of Deductions

1. **Automobiles.** The cost of operation and maintenance of an automobile used in making professional visits is deductible. These costs include gasoline, oil, tires, insurance, repairs, garage rental, driver's wages and depreciation. If the same car is used for both professional and personal purposes, only such part of the maintenance and depreciation as arises out of the use for professional purposes is deductible. Sums spent for taxi, bus, or railroad fare, *while on professional calls*, are deductible.

Depreciation is based upon the estimated useful life of the car. If that period be five years, 20 per cent depreciation based on cost price may be taken annually for five years. What has been said with respect to automobiles applies to other motive equipment.

2. **Bad Debts.** If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debts because "if his books are kept according to this system, he is only reporting as gross income those accounts which have proved to be good, and therefore bad accounts cannot be deducted because they have already been excluded."

If the books are kept upon an "accrual basis" (that is, on the basis of expenses actually incurred and payable even though not yet paid, or income earned although not yet collected), it is permissible to charge off all debts which have been definitely ascertained to be worthless, and have been charged off on the books or records during the fiscal year covered by the report.

3. **Library.** Most physicians maintain a professional library. Taken as a whole it is doubtful whether the useful life of such a library exceeds ten years. Accordingly, annual depreciation of 10 per cent of the cost of such library may be deducted.

4. **Medical Supplies and Instruments.** Medicines used in the physician's office to treat patients, bandages, laboratory materials, and all other medical supplies required for the operation of a physician's office may be deducted as necessary expenses, *as may equipment, the life of which is less than one year.*

The average useful life of surgical instruments and equipment generally is now estimated at ten years, which means that 10 per cent of the cost may be taken as reasonable annual depreciation. X-ray equipment may ordinarily be depreciated at 10 per cent of cost.

5. **Office Expense.** General office expense is deductible. Among the principal items are heat, light, office supplies, telephone, rentals, water, office equipment having a useful life of a year or less, and depreciation on office furnishings and fixtures. Ten per cent of original cost is a reasonable *average* depreciation rate for office equipment, furnishings and fixtures. Specific items may be higher or lower than this rate. Thus, a typewriter which, it was estimated, would last only five years would warrant a 20 per cent annual rate; while metal filing cabinets, with an estimated useful life of not less than twenty-five years, would justify only a 4 per cent annual rate.

Where the space used for the conduct of a professional practice, including waiting rooms, examination rooms and laboratory, is owned by the taxpayer physican, or by a partnership of physicians, a reasonable depreciation may be taken annually on such building, based on its cost and life expectancy. If only a portion of a building is used for professional purposes, depreciation may be taken only on such portion.

6. **Office Rent.** If a physician pays rent to another person for office space, he is permitted to deduct the amount from his gross income. This includes regular office space in a rented home provided office hours are maintained there. Where a physician maintains his offices in a rented home he may deduct as rental expenses only that proportion of the total rent paid which his office space bears to the entire house.

7. **Professional Dues and Subscriptions.** Dues paid to professional associations to which a physician belongs in the interest of his profession are deductible. Subscriptions to medical journals or scientific publications are likewise deductible as expenses.

8. **Taxes and Licenses.** Taxes paid upon materials required in professional work are deductible. All licenses which the physician is required to take out may be deducted. This includes the license to prescribe alcohol, narcotic license, automobile license, local occupational and reregistration taxes. State taxes on gasoline and motor oil, state income taxes paid, payments made under the Wisconsin unemployment compensation act and payments made by the physician as an employer under the Social Security Act are also deductible. The social security tax deducted from the income of a salaried physician is not deductible by him, however, since it is considered an income tax.

The physician may also deduct all real estate and personal property taxes paid by him, even though the property taxed is not used for professional purposes. This would include, for example, taxes on a vacant lot or on a launch.

Nonbusiness taxes paid during the tax year by one on a cash basis are generally deductible, except for: Federal income tax; federal estate and state inheritance taxes; federal or state gift taxes; federal excise taxes, such as those of theater tickets, jewelry, furs, silverware, transportation, cigarettes, telephone, and the like. Also non-deductible are: the employee's share of federal old age insurance tax; federal transfer taxes on corporate securities or real estate; state or local property assessments for improvements; and state and local taxes on tobacco and cigarettes which are not imposed on the consumer (including Wisconsin). Excise taxes on transportation and communications are deductible if paid in connection with business expenses. Transfer taxes on corporate securities and real estate are not deductible as such, but the amount thereof may be used to reduce the selling price, which has the effect of allowing them as expenses.

9. **Traveling Expenses.** Traveling expenses necessary for professional visits to patients are deductible. Traveling expenses in bona fide attendance upon scientific meetings are deductible. The expenses of attending postgraduate medical courses are *not* deductible, however.

10. **Wages and Salaries.** Deductions are permitted for the salary of a physician, nurse, laboratory assistant, stenographer or clerical worker employed in the office so long as the duties of such persons are in connection with the physician's professional work. Wages paid to maids taking care of the office and answering the telephones are also deductible, as are any sums paid employees for services rendered in connection with the taxpayer's practice, or the care and treatment of patients.

11. **Miscellaneous. (a) Legal Expenses.**—Legal expenses incurred in connection with the taxpayer's profession or business, including the prosecution of tax assessments or refunds, are deductible, but legal fees paid for general personal legal services are not deductible. Expenses incurred in the defense of a suit for alleged malpractice are likewise de-

ductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

(b) Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Under professional equipment may be included any automobile belonging to the physician and used partially or wholly for professional purposes.

(c) Laboratory Expenses—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of other corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when, under corresponding circumstances, they would be deductible if they were part of a physician's general office expense.

(d) Losses by Fire, Theft, etc.—Loss of and damage to a physician's equipment by fire, theft or other cause, *not compensated by insurance or otherwise recoverable*, may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent it has not been made good by repair and the cost of repair claimed as a deduction.

Deductions may likewise be taken for loss of or damage to *nonprofessional* property of a physician caused by fire, flood, theft, storm, or other casualty *where not compensated for by insurance or otherwise*. Examples of this type of casualty would include damage to trees and shrubs caused by storm or flood; damage to floors and furnishings caused by bursting water pipes; injury to boats or launches caused by storms; damage to a car, whether caused by the physician's negligence or that of someone else.

To repeat, such items as those above indicated *cannot* be deducted where, or to the extent that, the taxpayer is compensated for such loss by insurance settlements, law suits, or sums paid over without law suits by a person or persons causing the damage.

(e) Sale of Spectacles—Oculists who furnish spectacles, etc., must enter as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for services separate and apart from charges for spectacles.

(f) Medical Expenses. Medical, dental, drug, nursing, hospital, and related expenses, including fees for services rendered by other physicians, *which are in excess of* 5 per cent of the taxpayer's adjusted gross income, may be deducted if *actually paid* during a given year. The cost of hospitalization and surgical insurance may, except as provided below, be included in such deduction, as may travel where directly related to hospitalization or recuperation, and the travel expenses of a minor child and parent, which are directly related to hospitalization and medical care. The taxpayer cannot claim a deduction for travel for general health, unrelated to a specific condition requiring change of climate, or for general health travel combined with vacation.

Premiums for policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Such premiums are deductible whether the benefits are payable directly to the source of service, or as indemnity to the insured physician. Premiums for disability or time loss insurance, and for accidental death and dismemberment, are *not* deductible, however. Physicians enrolled in the Provident Life & Accident Insurance Company group disability and hospitalization plan, which has been carried through the State Medical Society since August 15, 1950, may deduct the hospital benefits portion of the annual premium, which is $17.

To the extent that any health expenses are compensated for by insurance or otherwise, they are not to be included. For example, if the annual cost of a hospital and surgical benefit policy during 1950 was $72, and $60 in benefits was received from such policy during the year, only the difference between the cost and the benefits, or $12, could be shown as the net cost of this medical expense item for 1950. If more than $72 was received in benefits during the year, *none* of the premium cost is deductible as medical expense, since the taxpayer received in benefits more than he spent as premium.

The maximum deduction for medical expenses on a separate return for one exemption is $1,250.00, and for two or more exemptions is $2,500.00. The maximum deduction in the case of a joint return by husband and wife is $2,500.00 where there are no other exemptions, as for dependents. This amount is increased to $3,750.00 where there is a dependent in addition to husband and wife, and to $5,000.00 where there are two or more dependents in addition to a husband and wife who make a joint return. Situations may arise where, by reason of the rule limiting medical expenses to the excess over 5 per cent of adjusted gross incomes of husband and wife, a joint return will decrease the medical deduction in some cases. This will seldom occur, however.

The expense must be for the medical care of the taxpayer, his spouse, or a dependent. Taxpayers are required to furnish the name and address of each person to whom such expenses were paid, and the amount and approximate date of payment. Where a joint return is filed, the 5 per cent limitation is computed on the aggregate adjusted gross income of husband and wife. Payments for waiver of premiums

on a life insurance policy are *not* includable as medical expense.

Example: Assume the taxpayer has a gross income of $10,000 and that the total of the medical, dental, hospitalization and related expenses paid in a given year for himself and his family was $1,500. Since there is no recognition given to such expenses up to the point where they equal 5 per cent of his adjusted gross income, the first $500 of his expenses are not deductible. He would, therefore, be allowed to deduct only the remainder, or $1,000.

(g) Installment Sales. Where a physician sells real estate, or where he makes a sale of personal property, such as his medical practice, or some other property which he is not in the business of selling regularly, and there is a profit on such sale, it is possible to spread that profit over a period of years, with consequent reduction in the income tax payable on such sale, assuming that he is otherwise in a favorable income position and so continues during the years when the balance of the payments are being made to him.

To gain such advantage it is required that the initial payment does not exceed 30 per cent of the selling price. The remainder, of course, can be payable in whatever manner the parties agree in subsequent years. As a general proposition where the profit on such a sale is substantial, it would probably be advisable to spread payments over three to five years, especially where the physician may not need the money at one time, and is secured on the balance.

In the case of personal property such as accounts receivable or a piece of machinery, it is also a requirement that the selling price must exceed $1,000.00.

There are two possible disadvantages which may diminish or eliminate the intended advantages of installment sales. One is that reduced income or deductible losses during one or more of the years of collection of an installment sale might be sufficient to offset part or all of the profit of the sale. A second possibility is that future Revenue Acts might eliminate the tax advantages now permitted in reporting long-term capital gains.

Nobody can foresee the future actions of Congress. It can only be said that to date those who have reported sales on an installment basis have in many cases derived a tax advantage from doing so. The matter should be carefully weighed by an attorney or a tax accountant.

(h) Interest Paid. With the two exceptions noted in this paragraph, all interest paid by a physician is deductible for federal tax purposes, even though it may have been for a non-professional indebtedness, such as the purchase of a home. The two exceptions are: (1) Interest paid on an indebtedness incurred to purchase or continue ownership of securities, the interest on which is wholly tax exempt; and (2) Interest paid on an indebtedness permitting the purchase of a single-premium life insurance or endowment contract. An insurance purchase is considered on a "single-premium" basis if substantially all payments are made within four years from the date of original purchase of such contract.

If a husband pays interest on an indebtedness of his wife, he cannot claim it on his individual return, and she may not claim it on hers, because it was not paid by her. It could be taken on a joint return, however.

II. STATE OF WISCONSIN

1949 Legislation

The 1949 session of the legislature made a number of changes in the income tax statutes, of which two are of special interest to physicians. One levied a surtax on individual incomes of 25 per cent of the normal tax to cover 1949 and 1950 incomes, whether on a calendar or fiscal year basis.

The second major change is in the optional "short form" of income tax return. This is available to a taxpayer who reports on a calendar year and whose income does not exceed $5,000. A husband and wife living together whose combined gross receipts do not exceed $5,000 may file a single joint return on the optional tax basis. The new law permits an optional standard deduction equal to 9 per cent of gross income, in no case to exceed $450.

In other words, a person or persons using the short form need not calculate deductions for interest, taxes, donations, and the like, but may use the optional standard deduction as in the case of the federal return. If a spouse dies during the year, the personal exemption of the survivor will be that of a married person.

If both husband and wife have enough income to require filing, both must file the optional form or take the optional deduction, or both must file the regular income tax form. The effect of the above changes is to bring the Wisconsin statutes for optional returns into substantial agreement with the federal short form and its provisions.

Since the limitation of gross income to $3,500 will exclude most members of the medical profession, and since most doctors must file the more detailed form 1, further details concerning the optional short form are not included herein.

Other changes enacted by the 1949 legislature are incorporated in the following text wherever applicable.

General Instructions

Returns of 1950 state income must be made to the assessor of incomes of the district in which the taxpayer resides, on or before March 15, 1951. A written extension of the time in which to file may be granted for sickness or other sufficient cause by the assessor of the department of taxation for the district in which the taxpayer lives. Such extension must be on written request, may not exceed thirty days, is discretionary in the assessor, and will not be granted because of mere neglect of the taxpayer.

Liability to Make Tax Return

Every resident, including minors over eighteen, must file a return whether notified to do so or not, if:

(1) He is single and his net taxable income is $800 or more.

(2) He is married, and his net taxable income, combined with that of his spouse, is $1600 or more.

(3) His gross receipts for the year total $5,000 or more, regardless of the amount of net income.

If the status of the taxpayer changes during the taxable year, insofar as it affects personal exemption for husband and wife, head of family, or dependents, such personal exemption shall be apportioned in accordance with the number of months before and after such change, disregarding a fractional part of a month unless it amounts to more than a half month, in which case it shall be considered as a month.

Every person having a legal residence in Wisconsin and every other person maintaining a permanent place of abode here, or spending in the aggregate more than seven months of the income year within the state, shall be deemed to be residing in Wisconsin for purposes of determining liability for income taxes and surtaxes. When a person changes his permanent residence to or from Wisconsin during the year, all income which follows residence may be reported on either of two bases. He must report all of such income received while a Wisconsin resident or that portion of such income for the entire year which the number of months' residence in the state bears to twelve, whichever is smaller. Personal exemptions are prorated on the basis of time of residence within and without the state.

Income Tax Rates

The normal tax, which is graduated, varies from 1 per cent on the first $1,000 of net income to 7 per cent on net incomes in excess of $12,000. The teachers' retirement fund surtax is based on one sixth of normal taxes after deducting $37.50 from the net normal tax. The 25 per cent surtax enacted by the 1949 session of the legislature is earlier discussed in the introductory paragraph of this section on page 1160.

Income From United States Taxable

All wages, salaries or fees derived from personal services, including services performed for the United States or any agency or instrumentality thereof, are now taxable. At present, all military income is subject to taxation. It is likely that effort will be made to change such provision retroactively.

Capital Gains and Losses

The former provisions of the statutes relating to computation of capital gains and losses for surtax purposes have been repealed. Thus, full gains or full losses are now recognized irrespective of the time the asset was held, instead of being graduated, as formerly, on the basis of the time the asset was held.

Annuity Rule

As distinguished from the federal rule governing annuity income, the Wisconsin rule provides that annuity payments under an endowment or annuity contract are income to the extent of any payment *after* the income tax cost (aggregate premiums or consideration) has been recovered. However, when the contract provides for the separation of the periodic payment into principal and interest, the interest so received is taxable when received.

Limits on Federal Tax Deduction

The deduction for *all* United States income taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income computable without the benefit of the deduction for such federal taxes, and *before* the deduction of contributions:

Example: The taxpayer's net income, for purposes of the Wisconsin return, before deduction of any United States taxes paid during 1950 and before deduction of contributions, is $5,000. He paid federal income taxes of $400 during 1950. Under the above limitation he could deduct only 3 per cent of $5,000, or $150 for federal taxes, although he had actually paid $400. This has the effect of subjecting a larger part of the taxpayer's net income to the Wisconsin law, even though the normal rates as such have not been increased.

Instructions on the Filing of Separate Income Tax Returns For Husband and Wife

The rules of the Department of Taxation provide:

1. If a wife has a separate income of her own and the husband and wife may not or do not elect to file a joint return on the optional tax form 1a, she must file a separate return on form 1W or optional tax form 1–Wa. In case she has no income, no return need be filed.

2. In the event that both husband and wife have income and file separate returns, the personal exemption of $17.50 for the head of a family may be divided between the two according to their own choice, that is to say, the husband may claim it all, or the wife may claim it all, or they may divide it between them as they see fit.

3. The earned income of children under eighteen years of age shall be included in the return of the husband, widow or head of a family, and the personal exemption for such children or dependents shall be allowed to the husband or may be divided between him and his wife as they may elect, or shall be allowed to the widow having such children. The exemption allowed to the head of a family, other than a widow or widower, supporting children under the age of eighteen shall be limited to a deduction of $17.50 from the tax.

Personal Credits and Exemptions

The statutes themselves are so clear as to personal exemptions, credits for dependents, and the date determining the personal status of a taxpayer for income tax purposes that they are quoted here in full.

"71.03 (2) **EXCLUSIONS.** There shall be exempt from taxation under this chapter the following:

(a) Pensions received from the United States.

(b) All inheritances, devises, bequests and gifts received during the year.

(c) All insurance received by any person or persons in payment of a death claim by any insurance company, fraternal benefit society or other insurer, except insurance paid to a corporation or partnership upon the policies on the lives of its officers, partners or employes."

* * *

"71.09 (6) There shall be deducted from the tax after the same shall have been computed according to the rates in section 71.09 (1), a personal exemption for natural persons as follows:

(a) For an individual, eight dollars.

(b) For husband and wife or head of a family, seventeen dollars and fifty cents. For the purposes of this chapter, the term 'head of family' means a natural person who maintained a household and supported therein himself and one or more persons who were dependent upon him for support; but no additional exemption shall be allowed for those dependent upon the head of a family except in case of a widow or widower supporting children under the age of eighteen years.

(c) For each child under the age of eighteen years who is actually supported by and dependent upon the taxpayer for his support, an additional four dollars.

(d) For each additional person, except persons defined in section 71.09 (6) (c), who is actually supported by and dependent upon the taxpayer for his support an additional $4, except in case of head of a family. In computing taxes and the amount of taxes payable by persons residing together as members of a family, the earned income of each child under 18 years of age shall be added to that of the husband or father, or if he be not living, to that of the head of the family and assessed to him except as hereinafter provided. The taxes levied shall be payable by such husband or head of the family, but if not paid by him may be enforced against any person whose income is included within the tax computation.

(e) If the status of the taxpayer, insofar as it affects the personal exemption for husband and wife, head of family and/or dependents, changes during the taxable year, the personal exemption shall be apportioned, under rules and regulations prescribed by the department of taxation, in accordance with the number of months before and after such change. For the purpose of such apportionment a fractional part of a month shall be disregarded unless it amounts to more than a half month, in which case it shall be considered as a month."

Deductions

A. Statute

The statute setting forth what constitutes allowable deductions of major items of expense is so clear that portions of it are reprinted here as an aid to physicians in making state returns:

"**71.05 Deductions from Incomes of Persons Other Than Corporations.** Persons other than corporations, in reporting incomes for purposes of taxation, shall be allowed the following deductions:

(1) Payments made within the year for wages or other compensation for services actually rendered in carrying on the profession, occupation or business from which the income is derived. But no deductions shall be made for any amount paid for services actually rendered in the carrying on of the profession, occupation or business from which the income is derived unless there be reported the name and address and amount paid each person to whom a sum of $700 or more shall have been paid for services during the assessment year. Except as provided in subsection (9) of this section, no deduction shall be allowed under this section for any amounts expended for personal, living or family expenses.

(2) The ordinary and necessary expenses actually paid within the year in carrying on the profession, occupation or business from which the income is derived, including a reasonable allowance for depreciation by use, wear and tear of the property from which the income is derived, and in the case of mines and quarries an allowance for depletion of ores and other natural deposits on the basis of their actual original cost in cash or the equivalent of cash.

(3) Interest paid within the year on existing indebtedness; provided, the debtor reports the amount so paid, the form of the indebtedness, together with the name and address of the creditor. But no interest shall be allowed as a deduction if paid on an indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under this chapter.

(4) Taxes other than inheritance and special improvement taxes upon the property or business from which the income hereby taxed is derived paid by such persons during the year, including therein taxes imposed by the state of Wisconsin or the United States government as income taxes; provided, that such portion of the deduction for federal income taxes as may be allowable shall be confined to cash payments made within the year covered by the income tax return; and provided further, that deductions for income taxes paid to the United States government shall be limited to taxes paid on net income which is taxable under this chapter; and provided further that income taxes imposed by the state of Wisconsin shall accrue for the purposes of this subsection only in the year in which such taxes are assessed.

(4a) The deduction for all United States income, excess or war profits and defense taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of the deduction of said United States income, excess or war profits and defense taxes, and before the deductions of amounts permitted by subsection (6) of this section. In no event shall any taxpayer be permitted hereunder a total deduction in excess of the actual amount of United States income, excess or war profits and defense taxes paid, and otherwise deductible.

(5) Dividends, except those provided in sections 71.03 (1) (e) and 71.03 (2) (d) received from any corporation conforming to all of the requirements of this subsection. Such corporation must have filed income tax returns as required by law and the income of such corporation must be subject to the income tax law of this state. The principal business of the corporation must be attributable to Wisconsin and for the purpose of this subsection any corporation shall be considered as having its principal business attributable to Wisconsin if fifty per cent or more of the entire net income or loss of such corporation after adjustment for tax purposes (for the year preceding the payment of such dividends) was used in computing the taxable income provided by chapter 71, * * *.

(6) Contributions or gifts made within the year to any corporation or association organized and operated exclusively for religious purposes, to any national organization of veterans of the armed forces of the United States or subordinate unit thereof, or to the state or any political subdivision thereof for exclusively public purposes, or to any corporation, community chest fund, foundation or association operating within this state, organized and operated exclusively for charitable, scientific or educational purposes, or for the prevention of cruelty to children or animals, no part of the net income of which inures to the benefit of any private stockholder or individual, to an amount not in excess of 10 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of this subsection.

(7) Amounts contributed for the given period to the unemployment reserve fund established in section 108.16 of the statutes, but not the amounts paid out of said fund.

(8) Losses actually sustained within the year and not compensated by insurance or otherwise, provided that no loss resulting from the operation of business conducted without the state, or the ownership of property located without the state, may be allowed as a deduction, and provided further that no loss may be allowed on the sale of property purchased and held for pleasure or recreation and which was not acquired or used for profit, but this proviso shall not be construed to exclude losses due to theft or to the destruction of the property by fire, flood or other casualty. No deduction shall be allowed under this subsection for any loss claimed to have been sustained in any sale or other disposition of shares of stock or securities where it appears that within thirty days before or after the date of such sale or other disposition the taxpayer has acquired (otherwise than by bequest or inheritance) or has entered into a contract or option to acquire substantially identical property and the property so acquired is held by the taxpayer for any period after such sale or other disposition. Reserves for contingent losses or liabilities shall not be deducted.

(9) Payment for expenses for hospital, nursing, medical, surgical, dental, and other healing services and for drugs and medical supplies incurred by the taxpayer on account of sickness or of personal injury to himself or his dependents in excess of $50 but not more than $500.

(10) Any and all sums not to exceed $800 paid by any person by way of alimony to a former spouse, but any person claiming a deduction under this subsection shall not be allowed a personal exemption for his former spouse under section 71.09 (6) (d)."

B. Index to Deductions

This index is designed to assist the physician in ascertaining what deductions are allowable. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail what deductions and depreciation are allowable.

Automobiles, 1.
  Depreciation.
  Driver, 1.
  Insurance, 1, 4.
  Maintenance.
  Professional use.
  Repairs.
Bad debts, 2.
Bandages, 9.
Conventions, 8.
Contributions and gifts, 16 (f).
Depreciation.
  Automobiles—20 per cent annually of cost price, 1.
  Instruments, 9.
    10 per cent annually of cost price of surgical instruments and general equipment; 10 per cent on x-ray equipment.
  Medical library, 6.
    10 per cent annually of cost price.
  Office equipment, 10.
    10 per cent annually of cost price.
Dividends received, 3.
Dues, 12.
Equipment. Rate must be reasonable.
  Office, 10.
  Professional, 9, 16 (a).
Fire, loss by, 7.
Instruments, 9.
Insurance premiums, 4.
  Automobile, 1.
  Hospital and surgical, 16(g).

Malpractice, 4.
Professional equipment, 4.
Interest paid, 5.
Laboratory materials, 9, 16 (a).
Legal expenses, 16 (b), 16 (d).
Library, 6.
Licenses, 13.
Losses, by fire, flood, theft, suit, etc., 7, 16 (d).
Medical convention, 8.
Medical expense, 16 (g).
Medical Society group health and accident annual premium, deduct $17. See 16(g).
Medical supplies, 9.
Miscellaneous, 16.
Office expenses, 10.
Heat, light, supplies, telephone, water, short-lived office equipment, annual depreciation on furnishings and fixtures.
Office rental, 11.
Postgraduate studies, 14.
Professional conventions, 8.
Professional dues, 12.
American Medical Association.
County Society.
State Society.
Special societies as:
American College of Surgeons.
American College of Radiology.
Any other paid in interest of profession.
Professional subscriptions, 6, 12.
Salaries, 15.
Sale of spectacles, 16 (c).
Scientific meetings, 14.
Subscriptions, 6.
Taxes and licenses, 13.
Automobile licenses.
Federal income—3 per cent maximum.
Import duties, etc.
Personal property taxes.
Professional license fees.
Real property taxes on office owned and used by taxpayer in practice.
Social security taxes.
Wisconsin income taxes and surtaxes paid.
Wisconsin unemployment taxes.
Theft, loss by, 7.
Traveling expenses, 8, 14.
Both professional calls and scientific meetings.
Wages and salaries, 15.
Clerk, 15.
Driver, 1.
Laboratory assistant, and technicians 15, 16 (a).
Maid, 15.
Nurse, 15.
Stenographer, 15.
Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 15.

C. Explanation of Deductions

In numerous instances below, references are made to numbered paragraphs of the federal portions of this tax summary. These will be found on pages 1157 to 1160 of this article. Where the text on federal taxes is equally applicable to Wisconsin returns, reference is made to the former so as to avoid needless repetition. Where the explanation applicable to Wisconsin income taxes varies from the federal, such explanation is separately given in the paragraphs following.

1. **Automobiles** (See paragraph 1, page 1157).

2. **Bad debts** (See paragraph 2, page 1157).

3. **Dividends Received.** Cash or property dividends received from a corporation's surplus accumulated since January 1, 1911, are deductible by the persons receiving the dividends, if the following requirements are fulfilled:

(a) The corporation paying the dividend must have filed a Wisconsin income tax return for the year preceding the payment of the dividend.

(b) The income of the corporation paying the dividend must have been subject to the Wisconsin income tax law for the year preceding the payment of the dividend.

(c) The principal business of the corporation paying the dividend must have been attributable to Wisconsin for the year preceding the payment of the dividend.

If 50 per cent or more of the entire net income or loss of a corporation, after adjustment for income tax purposes, for the year preceding the payment of a dividend, was used in computing the taxable income of such corporation, it will be considered that the principal business of such corporation was attributable to Wisconsin.

Note: Stock dividends do not constitute taxable income until the stock is sold. Liquidating dividends do not constitute taxable income until the taxpayer has recovered his cost of the stock so held. Any amounts received in liquidation in excess of the taxpayer's cost constitute taxable income.

4. **Insurance Premiums.** Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. This further includes premiums for various forms of insurance on the building owned and used in connection with the practice, or a fair proportion thereof where the building is also a home. Under professional equipment is to be included an automobile belonging to the physician and used partially or wholly for professional purposes.

5. **Interest Paid.** Interest paid within the tax year on existing indebtedness may be deducted, provided that the debtor reports the amount so paid, the form of indebtedness, and the name and address of the creditor. No interest is allowed as a deduction if paid on indebtedness created for the purchase, maintenance or improvement of income producing property, or for the conduct of a business, unless the income from such property or business would be taxable under the Wisconsin law.

Interest paid on state and federal income taxes is deductible, but interest paid on fines levied for violations of law is not allowable as a deduction.

Interest paid by an individual on indebtedness created for the purpose of acquiring a home is deductible from gross income. Likewise, interest paid by an individual on money borrowed to pay personal debts, such as hospital bills and other family obligations, is considered a proper deduction from gross income.

Interest paid by an individual on money borrowed for the purpose of securing an education is allowable even though other expenses of obtaining such education are not allowable.

6. Library. A fair rate of depreciation on the physician's library may be deducted covering wear and tear sustained through use. In determining the rate, however, obsolescence may not be considered since the Wisconsin income tax law does not recognize losses in value due to such causes. The fact that medical books become out of date during the course of ten years cannot be considered in determining the rate of library depreciation. An annual depreciation of 10 per cent of the cost of such library seems reasonable, however.

Costs of subscriptions to scientific medical journals essential to keep the physician abreast with the progress of his profession are deductible.

7. Losses by fire, etc. Loss of and damage to a physician's equipment and other property, used by him in connection with carrying on his professional practice, by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent that it has not been made good by repair and cost of repair claimed as a deduction. Losses on business conducted or property located outside the state are not deductible.

Losses on automobiles, aircraft, summer homes, motor boats, furniture, etc., purchased and held for pleasure are deductible from gross income where sustained because of theft, fire, flood, or other casualty. Losses on property used for both pleasure and practice are deductible only to the extent that such property was used in the practice, unless such losses were sustained through fire, flood, other casualty, or theft, in which cases the entire loss is deducted.

8. Medical Conventions. Ordinary and necessary expenses incurred in attending medical conventions or professional scientific societies, necessary to enable the physician to carry on his profession, are deductible.

Costs of attending professional conventions must be strictly limited to the necessary cost and expense directly attendant upon such conventions. The type of professional convention here contemplated is confined to such as are, as a general rule, ordinarily and generally attended by persons of the same professional standing as the taxpayer, as necessary to the maintenance and carrying on of their regular practice and profession.

9. Medical Supplies and Instruments (See paragraph 4, p. 1158).

10. Office Expenses (See paragraph 5, p. 1158).

11. Office Rental. If a physician pays rent to another person for office space he is permitted to deduct the amount from his gross income. This includes office space in a rented home, provided office hours are maintained. Where a physician maintains his offices in the home which he occupies as a residence, he may, if the home is rented, deduct as rent that proportion of the total rent paid which the value of his office space bears to the rental of the entire premises; and if he owns the residence, he may deduct the proper share of expenses attributable to the space so occupied, including taxes, depreciation, insurance, water, light, heat, repairs and general upkeep.

12. Professional Dues and Subscriptions (see paragraph 7, p. 1158).

13. Taxes and Licenses. All taxes and licenses incident to the professional scope of the physician may be deducted. The following taxes would be deductible by any physician:

(a) Real property taxes paid on office owned by him and used by him in his practice.
(b) Personal property taxes paid on his apparatus and equipment.
(c) Wisconsin income taxes and surtaxes paid.
(d) Federal income taxes, provided that such deductions are limited to taxes paid in cash within the year covered by the income tax return on net income taxable under the Wisconsin law, the maximum deduction not to exceed 3 per cent of net income computed under the state law *before* contributions.
(e) All license fees incident to his profession.
(f) Automobile licenses on automobiles used exclusively in the practice of his profession. See paragraph 1 supra.
(g) Import or tariff duties and business, license, privilege, excise, and stamp taxes, are deductible if incurred in connection with the carrying on of the taxpayer's practice and profession.
(h) All social security taxes paid by the physician in his capacity of employer and the amount paid by him under the Wisconsin unemployment compensation act. A salaried physician is required to include the amount of the social security tax paid by him in determining his gross salary. He is then permitted by the same rule to deduct the amount of the social security tax withheld from him and to include it as part of his federal income tax, subject to the 3 per cent maximum rule noted in subhead (d) above.

Taxes which are not deductible include: Real estate on residence property occupied by the owner; automobile license fee, gasoline, cigarette and amusement taxes, inheritance taxes, special assessment taxes; and taxes on vacant lots. However, doctors, traveling salesmen and others who use their automobiles in the production of their income may include the gas tax, and auto license fee as a part of the cost of operating the automobile.

14. Traveling Expenses (See par. 9, page 1158).
15. Wages and Salaries (See paragraph 10, page 1158 and 16 (e) below.
16. Miscellaneous.
    (a) Laboratory Expenses (See paragraph 11 (c), page 1159).
    (b) Legal expenses incurred in the defense of a suit for malpractice are deductible as business expenses. Expenses incurred in the defense of a criminal action, however, are not deductible.

    Legal expenses incurred in connection with the operation of a taxpayer's profession are proper deductions unless such business is conducted in violation of the law.
    (c) Sale of Spectacles (see par. 11 (e), p. 1159).
    (d) Unclassified. Payments required to be made to others for damages growing out of the carrying on of the profession such as injury to property, interference with property rights, breach of contract, and libel are deductible from gross income. Damages of a personal character recovered against the physician, such as those for the surrender of the custody of a minor child, are not deductible from gross income because not related to the carrying on of the physician's profession.

    Miscellaneous expenses which are incurred in producing taxable income and are allowable deductions include the following: fees paid to auditors, tax experts, and lawyers in connection with income tax matters, welfare work expense incurred in keeping up the morale in an office and organization.
    (e) Informational Returns. All salaries, wages, fees, or other compensation for services actually rendered in connection with the physician's practice which total or exceed $700 in the case of any individual recipient, must be reported or such expense shall not be deductible. This information, which must disclose the name, the address and the amount paid each such person, can either be furnished as a part of the income tax return or reported on form 9A, which form will be furnished the physician by the income tax assessor on request. Similar information must be furnished either on the return or on form 9A which should accompany the return, where deduction is sought on items of rent, royalty and interest expense.
    (f) Contributions or gifts made to public, religious, educational, charitable, veteran's, or other groups listed in section 71.05 (6), Wisconsin Statutes, 1949, quoted on page 1163 of this article are deductible to an amount not in excess of ten per cent of the taxpayer's net income for the fiscal or calendar year.
    (g) Medical expenses—payments in excess of $50 but not over $500 for hospital, nursing, medical, surgical, dental services and medical supplies incurred by the taxpayer on account of illness or of personal injury to himself or his dependents.

Premiums for policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Such premiums are deductible whether the benefits are payable directly to the source of service, or as indemnity to the insured physician. Premiums for disability or time loss insurance, and for accidental death and dismemberment, are *not* deductible, however. Physicians enrolled in the Provident Life & Accident Insurance Company group disability and hospitalization plan, which has been carried through the State Medical Society since August 15, 1950, may deduct the hospital benefits portion of the annual premium, which is $17.

Importance of Adequate Accounting Records

It is equally true under both the federal and the Wisconsin laws that a properly maintained set of double-entry accounts is probably the greatest single means of facilitating the preparation of a physician's income tax returns, and of enabling him to secure the maximum advantage from the exemption and deduction statutes. Such a bookkeeping system is neither complicated nor unreasonably time consuming. It can be installed by any competent accountant at a reasonable cost, and can be maintained by any trained bookkeeper. A large number of tax complications would never arise if adequate accounting records were available to serve as the basis of tax returns, or as the authority for settling questions at an early stage.

THE MEDICAL FORUM

SUMMON HUMANE SOCIETY TO SELL STRAY DOGS TO U.W.

Army Speeds Up Commissioning Process

Washington, D. C., Nov. 28.—The Army has stepped up its procedure for commissioning of medical reserves in an effort to insure that no man who wants to volunteer will be involuntarily inducted and deprived of the $100 bonus. Here is how the new system works:

At the time a registrant reports for physical examination, he has an opportunity—his last to apply for an army reserve commission as a volunteer. If he accepts, his records go to the Army area commander, who sends a letter of appointment if the registrant qualifies in other respects. Once he receives his notice, the registrant is expected to take the oath of office within 72 hours. Then he is to notify his Selective Service Board of his reserve status, and Selective Service will cease processing him.

DR. H. M. COON

10,200 Organizations Oppose Federal Health

Chicago, November 13.—A new count of the organizations which have gone on record as opposed to any form of compulsory health insurance shows a total of 10,206.

Attorney General Acts at Request of Regents

Madison, Dec. 7.—The attorney general of Wisconsin has served summons on Mrs. I. M. Kittleson, Madison, president of the Dane County Humane Society, and the humane officer of that organization, to show why they have not complied with the state law requiring humane societies to turn over stray dogs to the medical schools at the University of Wisconsin and Marquette University.

Dogs Essential

The action was taken after the regents of the University of Wisconsin asked the attorney general to "take appropriate action to obtain compliance" with the law to relieve the "unnecessary shortage" of dogs for teaching and research.

The regents were prompted to act after Dr. H. M. Coon of the University hospital said that "the use of animals for teaching and research purposes by the medical schools of the country is an essential part of the education of doctors, and the provision of improved medical service for the citizens of the country."

Dr. Coon pointed out the "advances that have come through this type of research," citing the work done with dogs which has resulted in saving the lives of bluebabies and other "cardiac cripples" and in saving the lives of diabetics.

Education Stymied

These, he said, "are the two presently outstanding achievements which owe their adaptation for the sufferers from these conditions to the use of the research animals and especially dogs."

Dr. Coon said that material for third-year medical students taking surgery is not available to meet "ordinary teaching needs." He added that the Dane County Humane society wrote him April 8,

(Continued on page 1173)

CHIROPRACTORS USE WEEKLY PAPER TO FINANCE $2,500,000 PROMOTION PLAN

Madison, Dec. 9.—The Committee for Chiropractic Education, with national headquarters in Houston, Texas, plans to use net proceeds from a weekly newspaper to help finance an advertising program for chiropractors, according to the Dec. 9 issue of Editor and Publisher.

After publishing eight experimental issues of the Chiropractic Challenger to test public reception, the committee has charted an extensive program to capture a million circulation within a year.

Designed to present the chiropractic side of the science of healing, the 16 page weekly tabloid made its debut last fall with a circulation of 100.000, of which approximately 50,000 were subscribed for by chiropractors for distribution to patients, former patients and prospective patients.

Having been "assured of public support by the overwhelming favorable reaction through voluntary layman subscriptions,' the CCE said it is completing plans to install its own printing equipment and mailing facilities.

Drawing on King Features Syndicate and other news organizations, the Challenger, when it reappears shortly after Jan. 1, will contain approximately 60% features and stories of general interest and 40% chiropractic news. Little or no advertising was solicited for the experimental issues. Only products that are not contrary to chiropractic philosophy will be acceptable when publication is resumed.

Net proceeds from the Challenger will be used for magazine, newspaper and radio advertising to convey the chiropractic message to the public. The committee also is conducting a $2,500,000 drive for funds to be used for education, research and the advertising program.

Announce Plans for 1951 Annual Meeting: Program and Section Chairmen Appointed

Madison, Nov. 24.—Dr. Peter A. Midelfart has been named Assistant Program Chairman to aid Dr. Warner S. Bump, Rhinelander, with the development of teaching demonstrations as part of the scientific program of the State Medical Society's Annual Meeting in 1951.

Plans for the 1951 Annual Meetin to be held in Milwaukee on October 1, 2 and 3 were outlined at the November 24 meeting of the Council on Scientific Work, according to Dr. F. W. Madison, Milwaukee, chairman of the Council.

T. O. Nuzum Named

Doctor Bump is program chairman for the 1951 meeting. Doctor T. O. Nuzum, Janesville, is chairman of postgraduate education, and the new representative of the Council on Scientific Work to the Coordinating Committee on Postgraduate Education. Dr. Joe Gale, Madison, is chairman of scientific exhibits for the 1951 Annual Meeting.

The following men were named as section chaimen for the 1951 meeting:

Drs. O. O. Meyer, Madison, Internal Medicine; Thomas Leonard, Madison, Obstetrics and Gynecology; Thomas Tolan, Milwaukee, Ophthalmology & Otolaryngology; K. J. Winters, Milwaukee, Pediatrics; Paul Snowden, Monroe, Radiology; and Jerry McRoberts, Sheboygan, Surgery.

Demonstrations will be presented on fractures, anesthesiology, hearing defects, obstetrical problems, and x-ray interpretations.

No Motion Pictures

No medical motion pictures will be shown at the coming Annual Meeting. Hospital staff conferences will be continued on Monday morning of the Annual Meeting.

There is a possibility that these conferences will be coordinated into one large meeting, with staffs of Milwaukee County Hospital, Veterans Hospital, and Childrens Hospital participating in a single meeting.

Doctor Bump is planning to develop several coordinated symposia instead of having a series of unrelated papers.

DR. P. A. MIDELFART

Wage Earner Survey Shows Opposition to Socialized Medicine

Chicago, October 30.—A recent survey of representatives of the nation's wage earners reveals some interesting feelings about the question of socialized medicine.

The survey, called the Wage Earner Forum, was sponsored by MacFadden Publications, Inc., and is made up of a panel of some 1,500 wage earner families.

In the latest survey, the following question was asked:

"In England they have what is known as Socialized Medicine—that is, the government supplies free medical and health service to the people. There is talk of having such a plan in the United States. Will you favor such a plan here?"

The replies indicated that 27 per cent of the total panel favored such a plan; 46 per cent were opposed to it and 27 per cent felt they didn't know enough about it.

Of those who favored the plan, 30 per cent belonged to unions; 21 per cent were non-union. Of those who said no, 42 per cent belonged to unions and 52 per cent were non-union. Opposition is greatest in the older age brackets. Opposition is also highest in the midwest.

A substantial number of those who are in favor of socialized medicine say they favor it because the American Medical Association is opposed to it.

Set New Policy on Veteran Malaria Cases

Madison, Dec. 1.—Fee-basis physicians who examine veterans with service connected disabilities are requested to forward blood smears found to be positive for malaria to the Milwaukee Regional Office of the Veterans Administration.

The Wisconsin Veterans Medical Service Agency of the State Medical Society has been advised that "a prepared slide of the veterans blood smear, when found to be positive by the examining physician, is to be sent to the Milwaukee Regional V. A. office laboratory. If the interpretation is still positive, the prepared slide will be mailed to the Director of the Veterans Claims Service in the Central Washington Office with proper identification of the veteran, including C-number and time and place of smear. This is necessary before further acceptance of the diagnosis of malaria for rating purposes."

Atomic Energy Book Available to M. D.'s

Washington, D. C., Dec. 3.—The 'Sourcebook on Atomic Energy", a comprehensive review of basic non-secret atomic energy information prepared under the direction of the United States Atomic Energy Commission, will be published December 4 by the D. Van Nostrand Company, New York, New York.

The sourcebook is considered suitable for use by anyone interested in the scientific and technical aspects of atomic energy. It may be obtained from the publishers at $2.90 per copy.

ARMY STARTS NEW "PREVENTIVE" UNITS

Washington, D. C., November 14. —New preventive medicine units, consisting of six officers, one warrant officer and 59 enlisted men, are being organized by the Army for duty in the Far East.

Each unit is responsible for malaria control and survey, inspection of field sanitary conditions and control of insect-borne, waterborne, and other diseases.

4-H CLUB MEMBERS PRAISE SMS FOR SPONSORING TRIPS TO HEALTH CAMP

Madison, Dec. 8.—The State Health Camp scholarships provided for worthy 4–H club members by the State Medical Society and many county medical societies are giving many young people and their leaders an opportunity for health education that may never come to them in any other way.

Each year the State Medical Society provides $100 to pay the expenses of from 5 to 10 outstanding 4–H club members to a "Health Camp" at Green Lake. While there they study personal hygiene, nutrition, home and farm safety and sanitation and methods of clean, healthy living.

Several county medical societies have realized the importance of this avenue of health education and established funds of $10 to $25 to send several 4–H delegates to this camp.

Most delegates write the medical society about their experiences, and expressing thanks for the opportunity. The following are excerpts from some of these letters:

Mrs. Theo Jensen, Coddington Club Leader: **"I feel that attending a 4–H Health Camp is one of the biggest awards a member or leader of the greatest organization of youth in this country could receive. Would that more could be given that privilege."**

Verne Buhl, Route 1, New Holstein: **"This was one of the most wonderful experiences I have ever had. I had no idea what was being done by the Health Camp. I learned a lot of new ideas."**

Jean Brecklin, Woodford: **"I learned a lot, and the rest of the members think that what I learned will help all of them too."**

Margaret Ort, Black Creek: **"I learned so much about how to encourage good health among others and have many ideas to convey to my club."**

Anne Tollefson, Orfordville: **"I was especially happy about this scholarship, because now I know I'd like to enter the nursing profession, and I learned many things that will be of great use."**

Robert F. Morgan, Jr., Oconomowoc: **"The camp is an inspiration to every boy and girl who spends even a day there. We had every chance to find out new things about our health."**

Raymond Claas, Route 3, Milwaukee: **"Thank you for giving me a chance to go to a Health Camp. I am an American, but I still talk German because my Dad speaks German. My going to camp did me a lot of good and I learned a lot."**

Mrs. Louis Schmidtknecht, Alma: **"The wonderful leadership of Miss Agnes Hansen (Assistant State Club Leader, Madison), the county extension agents and the health speakers from Madison made this Health Camp a most interesting gathering. I'm sorry more boys and girls cannot attend."**

Conrad Schlaefer, Germantown: **"One of the most interesting and educational trips in 4–H club work is the annual meeting at the State Health Camp."**

Sponsorship of the 4–H club scholarships is under the direction of the Committee on Rural Health, Dr. M. W. Stuessy, Brodhead, chairman.

SCHEELE AGAINST MASS BLOOD TYPING

Chicago, November 13.—Surgeon General Leonard A. Scheele said in an address in Washington recently that he believes it would be a waste of time to undertake mass blood typing of the population in anticipation of an atomic attack.

His statements supported the views previously expressed by the A.M.A. Committee on Blood Banks, of which Dr. W. D. Stovall, Madison, is a member.

Dr. Scheele, who heads the U. S. Public Health Service, said there is "reasonable doubt of the method's effectiveness."

Moreover, he said, it would place an unwarranted drain on manpower and on supplies for typing serum, and run the risk of errors by "hastily trained personnel."

He urged defense planners to concentrate on building up local supplies of whole blood, plasma, and plasma substitutes.

Neenah Kiwanis Oppose Compulsory Health Plan

Neenah, November 10.—The Neenah Kiwanis Club has recorded its opposition to the proposed "compulsory health insurance plan" and copies of the resolution are being sent to all congressional representatives.

Chester Bell, Kiwanis president, read the resolution at a November 8 meeting. The Kiwanis' opposition is based on the belief that such a plan would impair rather than aid health services, that it would increase already heavy tax burdens, that it is unnecessary because of the rapid spread of voluntary plans and because it "is only another name for socialized medicine."

IT TAKES MORE THAN WORDS

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MARYLAND DOCTORS DEVELOP A NEW INDIGENT CARE PROGRAM THAT WORKS

Baltimore, November 15.—Operating under a plan originated by the medical practitioners themselves, Maryland is demonstrating how a state can improve the medical care of the indigent three per cent of its population without impairing the doctor-patient relationship and without lowering the dignity of those under treatment.

Free Choice of M. D.

The Maryland Plan, best known of four statewide medical relief programs, is based on the cooperative action of doctors, dentists, public health authorities and the citizens.

Care is furnished the indigent throughout the state's 23 counties by the patients own doctors and dentists and in 36 general hospitals.

The "medically indigent"—persons able to meet ordinary living expenses but not the costs of illness—may apply for similar care.

Medical Society Active

The bills are paid, at an agreed upon rate, by the state, which also pays for essential drugs and supplies. The patients are free to choose and to change their doctors,. and the doctors may accept or reject patients.

A Johns Hopkins professor called the all-Maryland health conference in 1939 that touched off the chain of reaction which brought the plan into being. More than one hundred leaders of civic, labor, rural, educational, religious and other groups present at the conference were outspoken in their criticism of the medical care the needy were then receiving.

The medical profession took action. The state medical society proposed that a committee be set up under the State Planning Commission. This committee made a careful three-year study of medical conditions throughout the state and proposed that the Maryland medical program be set up. It was passed by the State Legislature in 1945.

Issue Benfits Card

The State Department of Health administers the program for the counties, and much of its success is credited to the fact that all have full-time health officers, all of whom are physicians working in cooperation with private practitioners.

The local welfare department certifies the relief clients to the local health department, which gives to each the little white card entitling the holder to medical care. In addition the medically indigent may apply to the health department and, if they meet a financial eligibility test, also receive the white card.

Every county has its local advisory council. Through it the Grange, county agent, superintendents of schools, welfare departments and voluntary health organizations help doctors guide the medical program, and adapt it to local conditions.

Offered at Public Sale!

One broken-down Brannan Plan
One socialized medicine scheme
One million bottles of red ink
One million pounds Polish ham
One afternoon mail delivery, badly used
One hundred million pounds of strong butter, unfit for hogs
One million pumpkins, good for hiding important papers
Unlimited quantity, State Department sleeping pills,
no prescription needed
Terms: New Deal 57-cent dollars
A deep freeze free to first 100 customers
HURRY! HURRY! HURRY!
Your dollar will be worth much less

Paul Revere Messages

New Zealand Medical Plan Facing "Collapse"

Chicago, November 17.—The widely hailed "social security" medical plan of New Zealand is "collapsing under its own weight" according to a correspondent writing in a recent issue of the Journal of the American Medical Association. The article referred to the annual report of the director of clinical services of New Zealand which said:

"Increases in the cost of general medical services and pharmaceutical supplies have been of such magnitude as to lead to serious misgivings as to whether state medical insurance against sickness is practicable or whether the best method of payment for services has been adopted."

The Journal correspondent said that when the plan was started in 1938, the scheme was welcomed "with its free medicine, free hospitalization and nominal payments for medical attendance. But the original humanitarian concept has become a political football. Year by year benefits have been increased as a bait for the electors until today the cost of social security is the biggest item in the national budget."

Disability Insurance Beaten in Washington

Chicago, November 10.—The voters of the state of Washington defeated on November 7, by a vote of 3 to 1, a cash sickness bill which had been in effect for more than a year.

This is the first time in which the voters could express their preference for or against a statutory disability bill, according to the Health and Accident Underwriters Conference.

The law was passed by the Legislature in 1948, but it was referred to the voters after a petition calling for a referendum was signed by more than the required number of people.

Cash sickness bills are now compulsory in three states and provide for protection against wage loss due to non-occupational sickness and injury. The first plan was enacted in Rhode Island in 1942. This was followed by similar plans in California, New Jersey, and New York.

CHIROPRACTORS CAN'T ADVERTISE AS NATUROPATHS

Face Loss of License, Attorney General Says

Madison, Dec. 8.—Licensed chiropractors are not authorized to treat the sick by naturopathic methods and may not advertise themselves as naturopaths, according to ruling by Attorney General Thomas E. Fairchild.

He gave the opinion to the State Board of Examiners in Chiropractic.

In a ruling which discussed the definitions and scope of chiropractic and naturopathy, Mr. Fairchild pointed out that a "chiropractic license does not authorize or encompass the employment of many of the techniques employed by naturopaths in the diagosis, prescribing for, and treating of human illnesses."

He concluded that one who is licensed only to practice chiropractic and holds himself out to the public as a naturopath is guilty of deceiving or defrauding the public.

Such unprofessional conduct and advertising constitute grounds for revocation or suspension of license by the board, Mr. Fairchild said.

He explained that Webster defines naturopathy as "A system of physical culture and drugless treatment of disease by methods supposed to simulate or assist nature." Gould's Medical Dictionary (5th Ed.) says naturopathy "excludes the use of drugs, surgery, x-ray or radium," according to Mr. Fairchild.

Describes Naturopathy

He pointed out that naturopaths have enlarged upon and "particularized" these definitions so that actually they treat the sick as that term is defined by the Wisconsin Medical Practices Act.

Mr. Fairchild cited an article in the May, 1950, "American Mercury" by Robert A. Wood, a Chicago practitioner who was president of the American Naturopathic Association of the State of Illinois for many years.

In the article, Wood described the naturopathic treatment of appendicitis by fasting, cold water enemas and a diet of fruit and raw milk; syphilis by the "eliminative, fast, and health-food treatment"; gall stones by a fast on river water and lemon juice followed by a 10 day acid fruit diet, hot packs and sun baths; and bone tuberculosis with Sitz baths, cold sprays, hot packs, infra-red vibrations, exercise manipulations, etc.

Mr. Fairchild noted that chiropractic, under practically all definitions, is confined to "manipulations of articulations of the human body, and adjustment of the spinal column by hand."

Naturopaths are licensed in some states such as California, Texas, Indiana, South Carolina, Florida, and possibly some others, according to Mr. Fairchild. They are not licensed in Wisconsin, although attempts have been made to secure such legislation. The latest effort was in 1947 when such a bill passed the assembly, but was defeated in the senate.

Propose State Subsidy for Public Health Units

Madison, Dec. 1.—The Legislative Council is now studying a state subsidy proposal for county health units to enable inhabitants of rural areas to obtain the health services now almost standard in most municipalities.

The proposal, drafted by the State Board of Health, provides that each county be granted aids amounting to fifty cents per person yearly for the operation of local health agencies, commonly called county public health departments.

According to Dr. Carl N. Neupert, State Health Officer, only 30 to 40 county health departments would be required to do a better job of public health work than the present inefficient system of 1,000 part-time lay health officers in the smaller villages and towns.

VA Won't Pay for ACTH or Cortisone Prescribed for Outpatient Vets

Milwaukee, November 2.—The Veterans Administration has announced that it will not pay for cortisone and ACTH prescribed by fee-basis physicians for the outpatient treatment of veterans.

The Wisconsin Veterans Medical Service Agency of the State Medical Society has been notified by Dr. H. L. Vogl, chief medical officer of the Milwaukee regional office of the Veterans Administration that it has received the following communication from the central office of the VA:

"The chief medical director has requested that all fee-basis physicians be contacted immediately and advised that cortisone or ACTH cannot be prescribed for VA beneficiaries at government expense on an outpatient basis.

"The pharmaceutical Associations are being advised not to accept prescriptions for cortisone or ACTH after November 15, 1950, pending policy letter.

"A revision of policy relative to use of cortisone and ACTH is presently under development in central office and as soon as this policy is known to us, you will be advised."

Immediate notification of physicians is essential because the food and drug administration has approved shipment of cortisone through interstate commerce and this may produce a large number of veterans being started on cortisone or ACTH.

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NEW FILM READY FOR PUBLIC USAGE

Chicago, November 13.—A new film, "Your Friend, the Doctor", was recently released by Coronet Instructional Films, Inc., Chicago.

The film portrays the role of the family physician in the school and home and stresses his friendly guardianship of child and family health.

Showing this 16 mm. sound film before Parent–Teacher groups and others concerned with family-school-physician relations is desirable. Fred V. Hein, Ph.D., and Donald A. Dukelow, M. D., of the A.M.A. Bureau of Health Education, served as consultants on the film.

Local medical societies can obtain the film directly from Coronet Films, Inc., 65 East South Water Street, Chicago.

Medical Schools Get $73,000 in Grants

Washington, D. C., November 3.—Wisconsin medical schools will receive a total of $73,000 in teaching grants from the public health services National Heart Institute.

Marquette University School of Medicine will receive $14,000 and the University of Wisconsin Medical School will receive $59,000 under a teaching grant program which assists medical schools in expanding and improving their cardiovascular teaching curricula.

Help Fight TB

Buy Christmas Seals

DOCTORS DIAGNOSE THEMSELVES; FIND THEIR PUBLIC RELATIONS STILL AILING

Madison, Dec. 8.—What happens when a doctor goes to the doctor?

About 300 physicians representing most state and county medical societies in America placed the collective body of the medical profession on the examining table at the AMA's public relations conference in Cleveland on December 3–4, and did a little self-diagnosis.

The probing was deep, and sometimes painful, but the diagnosis was clear and concise: medicine's public relations is still ailing.

To be sure, the general condition of medicine's "PR" has improved in recent years, but not all ailing areas have improved at the same rate.

If the diagnosis was plain, then the course of treatment prescribed at Cleveland was unmistakably clear: Every doctor and county medical society should take a good, big dose of humility and go on a strict diet of honest, sincere, competent service to patients and community.

This treatment was prescribed by a series of consultants, both doctors and laymen. Dr. Eugene A. Ockuly, president of the Toledo, Ohio, Academy of Medicine, had this to say:

> **"The American Medical Association can't improve public relations at the local level. Any effort to improve medicine must stem from a strong, united local profession. In Toledo, we put teeth into the rules that enforce moral and ethical aspects of medical care—that's vital for better public relations."**

Dr. Russell B. Roth, secretary of the Erie County (Pa.) Medical Society, declared:

> **"Doctors have a greater obligation than just to the sick. And they can't put a price tag on their services to the community."**

Dr. R. B. Chrisman, Miami, secretary of the Dade County Medical Society, pointed out a first principal of sociology that doctors should follow:

> **"You can't go any farther or any faster than you can take others with you. Give every doctor in your medical society a part to play and you will soon have his support."**

Dr. Fred Sternagel, West Des Moines, chairman of the Committee on Medical Service and Public Relations of the Iowa State Medical Society, declared:

> **"Doctors must actively participate in lay community groups. Most of the time we stay away until they do something we don't like, then we holler to high heaven. If there's any blame for poor relationships between doctors and such agencies, it is the doctors'."**

The prescription for ailing public relations is not always easy to take, the conference concluded, and sometimes it is difficult to administer.

What can be done? The doctors concluded that certain activities are essential:

1. **A working system for handling night and emergency calls in every city or county, no matter how few doctors may be involved.**
2. **Improved methods of collecting delinquent accounts—methods that recognize the patients' problems and offer an honorable and relatively easy solution.**
3. **Grievance or similar committees to come to grips with the incompetent or unscrupulous physician.**
4. **Effective medical participation in community affairs.**
5. **Greatly increased health information and education activities to tell the story of medicine and its efforts to deal with health problems right in the community.**

In view of what occurred at the conference, it may be significant that it had the largest attendance and tackled more specific public relations problems than any the AMA has ever sponsored.

Doctors Urged to Attend Industrial Health Meet

Chicago, November 13.—Safeguarding the health of workers will feature the 11th annual Congress on Industrial Health which will be held in Atlanta's Biltmore Hotel, February 26–27.

Large C.I.O. Union Kicks Over Traces to Blast Growing Federal Encroachment

Madison, Dec. 8.—A publicity blurb for John T. Flynn, author of "The Road Ahead," recently brought to light a C.I.O. union's fears that federal government encroachment in private industry is threatening the American way of life.

Flynn's promotional literature called attention to a New York Times report of April 30, 1950, on the annual convention of the Utility Workers Union of America, C.I.O., at New York the day before.

The Times reported that a resolution, passed unanimously, had termed the "creeping paralysis of nationalization of the electric industry" as the "first step down the socialistic highway."

Although this resolution may express the views of the utility workers, it is surprising and paradoxical in view of the C.I.O.'s firm stand in favor of national compulsory health insurance or "socialized medicine."

"Control of the electric industry is the key to control of the major industries of the nation, the control of transportation, mining, agriculture and all basic industry," the Times quoted the report. "This is the first step down the socialistic highway. Then transportation, communication, steel and the rest will follow to put an end to our American way of life."

Noting the increasing trend toward Government participaion in the utility business in competition with private industry, the resolution declared that if this were permitted to continue "we will soon have authorities, not elected but appointed, who will constitute a supergovernment with control of practically all the electric power in the nation."

Declaring that job security, promotional opportunity and working conditions too often became the "tools" and "plums' of politicians and that wages and working conditions were fixed by political management, the resolution said that union members employed by Federal agencies and municipalities that operate their own light and power business work "under conditions inferior to those enjoyed by our members employed in private industry."

Health Councils Need Support of Doctors

Detroit, Michigan, October 20.—Physicians have a clearcut responsibility for the organization of health councils which have both lay and professional participation.

This was the major conclusion of a conference on "M.D. Participation in Health Councils" held in Detroit, Michigan, on October 1.

DR. A. A. FILEK

Dr. Allen Filek, director of the division of local health administration of the State Board of Health, represented the State Medical Sociey at the meeting.

Mr. Keith Tanner, director of the field services division of the Michigan Farm Bureau, said that farm people are vitally interested in health but that they are confused. He said a health council eliminates that confusion by providing roads on which to travel to better health.

Mr. Tanner pointed out that it is not enough for the physicians to contribute dollars and cents to a health council. "That isn't what farmers want," Tanner said. "They want the physician to be a part of the team and to participate with his presence and action."

One of the recommendations of the Detroit meeting was that state medical societies recommend active participation whenever a community council is being organized, and that it follow up with personal visits, if necessary, to see to it that the county medical society officers do their part in following through.

HUMANE SOCIETY—

(Continued from page 1167)

following a series of conferences held between the Medical school faculty and Humane society members, that its board had voted 7 to 10 not to turn dogs "over to the University for experimental purposes."

At one of the meetings between members of the Medical school faculty and the Humane society, the school was told "that approximately 350 dogs per year would be available." Details of payment for the dogs and their care were also discussed at the meetings, Dr. Coon said.

Dr. Coon further explained that a law passed by the Wisconsin legislature in 1949 provided that 'by permitting the humane use of animals . . . it is the purpose of this section to assure that there shall be an adequate supply of dogs for these purposes."

The law also provides that humane officers shall turn over dogs to the University of Wisconsin and Marquette university medical schools.

"On Sept. 26, 1950, in order to be prepared for the teaching needs of the medical school, a requisition was placed in the hands of the city police department to be forwarded to the humane shelter. This requisition called for 10 dogs. There has been no response to this requisition and it is for this reason that the surgical training of the third year medical class finds itself at a standstill," Dr. Coon pointed out.

"The question is," Dr. Coon continued, "shall the laws of the state of Wisconsin be flouted by a small number of antimedical people and thereby hinder the teaching of medical students and the training of doctors for which there presently is a great need, not only for civilian but military usage?"

PLAN TO SET UP STUDENT AMA

Chicago, November 13,—Delegates representing student bodies in medical schools in the United States will meet at A.M.A. headquarters in Chicago, December 28–29, to draft a constitution for the Student American Medical Association.

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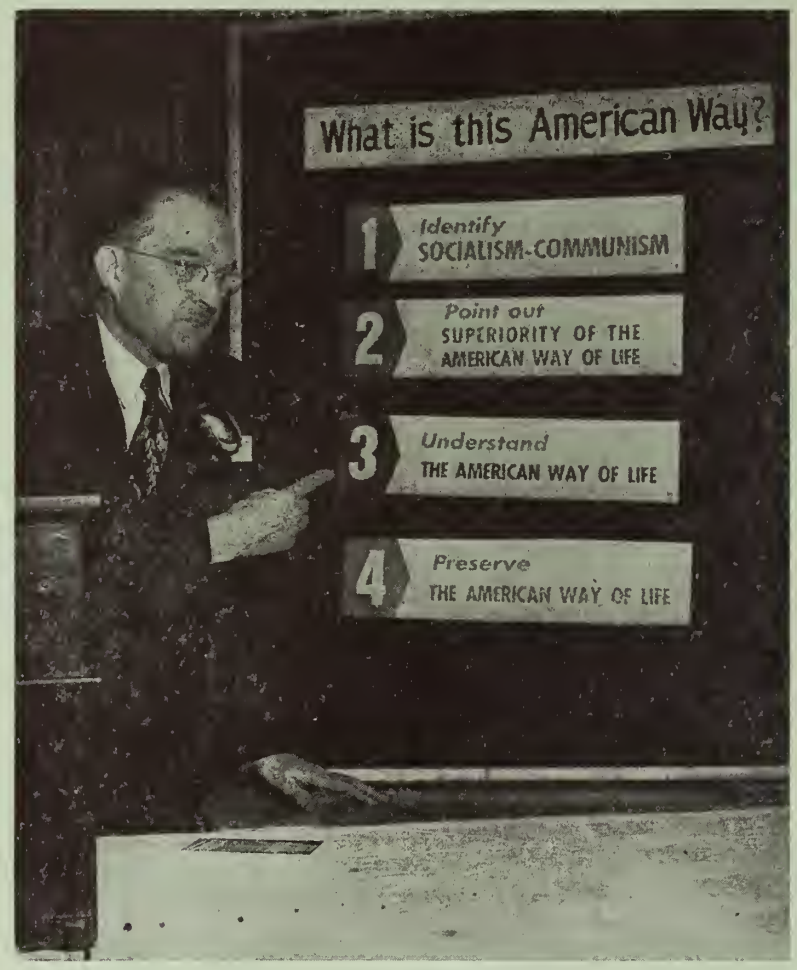

Fond du Lac Executive Urges M. D.'s to Expand Education for Freedom

Cleveland, December 4.—America is being undermined by zealots whose avowed purpose is the destruction of the American way of life, declared Mr. R. W. Mills, Fond du Lac, Executive Secretary of the Fond du Lac Association of Commerce, in a speech before the Third Annual Medical Public Conference at the American Medical Association's Cleveland meeting.

Names Organizers

In a stirring speech for the preservation of the American way of life, Mr. Mills traced the development of socialism and communism in the European nations, and its parallel development in this country.

So far, he said, Americans have been blind to the openly communistic activities of such individuals as H. S. Rauschenbush, Norman Thomas, and William C. Foster. Rauschenbush has written books recommending the overthrow of the free enterprise, profit system, Thomas is a leader of the socialist movement, and Foster is being investigated now for his communist activities.

Side Door Approach

"While these men have been directly undermining your American way of life, others are busy at the side doors trying to socialize industry, farming, education, housing, and medicine," said Mr. Mills.

He urged all individuals, businesses, and associations to carry on educational programs for the preservation of freedom.

He said that there are four steps in this process; identify socialism and communism, point out the superiority of the American way of life, and understand and preserve this way of life.

Ewing Made "Czar" of Medical Supplies

Washington, D. C., Dec. 4.—Federal Security Administrator Oscar R. Ewing has been cloathed with authority making him virtually a "czar" on priority grants for material required in hospital construction and domestic distribution of medical supplies and equipment.

Designation of the Federal Security Agency as a "claimant agency" under authority of the Defense Production Act places great powers, not yet fully understood even by government officials, in the hands of Administrator Ewing.

Ewing is Solicitor

He is, in effect, appointed as "claimant" or solicitor before the Department of Commerce (which makes decisions on priorities) on applications for steel, lumber and other materials needed for all hospital construction other than military and veterans.

Control also is his relative to "domestic distribution of supplies and equipment needed in the fields of health, education, welfare, recreation and related activities."

In immediate charge of the new setup is Paul Caulk, executive officer in the Surgeon General's office. He is responsible to an assistant to Ewing in charge of coordinating FSA's civil defense activities.

Waukesha Doctors Back Mental Hygiene Clinic

Waukesha, November 10.—The Waukesha County Medical Society has petitioned the county board to provide financial backing for the County Mental Hygiene Clinic.

In a resolution which said that the clinic is playing an important part in preventing mental illness in Waukesha County, the medical society "strongly and sincerely" urged that the county board give serious thought to the petition of the Council for Child Welfare which seeks financial backing for the venture they have carried on up to this time.

The state of Wisconsin has furnished the clinical psychologist for some time at its own expense, but now expects that the local organization will assume the responsibility for the salary of this individual.

Transactions of the 1950 Regular Session, House of Delegates, State Medical Society of Wisconsin

FIRST SESSION

Sunday, October 1, 1950

THE first session of the House of Delegates of the State Medical Society of Wisconsin, held at the Hotel Schroeder, Milwaukee, convened at 3:15 p.m., Dr. W. S. Stewart, Speaker of the House, presiding.

REPORT OF COMMITTEE ON CREDENTIALS

The Committee on Credentials, composed of Drs. C. O. Schaefer, Racine, chairman; T. F. Farrell, Prairie du Chien; and J. A. Enright, Milwaukee, verified the registration of 46 delegates, and four alternate delegates entitled to vote at this session of the House of Delegates. In addition, four alternate delegates, 10 councilors and three past presidents registered their attendance.

On motion of Doctor Schaefer, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll totaling 50 was accepted as the official roll of this session of the House, to stand for the entire session.

APPOINTMENT OF REFERENCE COMMITTEES

Speaker Stewart made the following appointments to reference committees:

To the Reference Committee on Reports of Officers: C. E. Zellmer, Antigo, chairman; E. C. Cary, Reedsville; and W. H. Costello, Beaver Dam.

To the Reference Committee on Reports of Committees: J. S. Allen, Norwalk, chairman; L. O. Simenstad, Osceola; O. W. Saunders, Green Bay; and J. W. Prentice, Ashland.

To the Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: Norbert Enzer, Milwaukee, chairman; W. A. Munn, Janesville; R. E. Garrison, Wisconsin Rapids; S. W. Hollenbeck, Milwaukee; and J. H. Houghton, Wisconsin Dells.

To the Fact-Finding Committee: P. B. Mason, Sheboygan, chairman; A. A. Cantwell, Shawano; F. E. Drew, Milwaukee; and G. J. Schulz, Union Grove.

Speaker Stewart stated that the Fact-Finding Committee had been appointed for the purpose of answering questions and presenting facts to delegates with regard to matters before the House of Delegates. He urged delegates to appear before the committee to present their problems and ask questions.

MINUTES OF THE 1949 REGULAR SESSION

The next order of business was the approval of the minutes of the 1949 regular session of the House of Delegates, as published in the December 1949 *Wisconsin Medical Journal.*

Dr. A. A. Cantwell, Shawano, made the following statement: "Mr. Speaker, I have found in that report that there was a speech I made before the House that was not included. Who censors those speeches? They are in the transcript, and it is going to be a fast move to have them admitted to the minutes. Some of you people were here when I made a speech, and I think the public is entitled to know what is said or is not said. The speech is not in the minutes. It is in the transcript, but it was not published. I would like to know why."

At this point, Secretary Crownhart made the following statement: "Mr. Speaker, I have requested that the transcript be brought down, as I understood this question was to be raised.

"The secretary is entirely responsible for the preparation of the minutes of all sessions of the House of Delegates and assumes that responsibility. Doctor Cantwell's talk, as well as a talk by Doctor Prentice, at the last session, did not seem to bear any substance that needed to be prolonged in the *Journal*, and I exercised my discretion by editing it out.

"Of course, it is within the rights of the House to order it printed. As soon as the transcript comes down from the eighteenth floor I will read you the remarks . . . . . .

"These remarks were made, Doctor Cantwell, and by reading them now I read them into the record of the 1950 session of the House. If the House so instructs me, I will reproduce them in the *Journal* this coming December.

"DOCTOR CANTWELL: Mr. Chairman, I served as secretary of the Committee on Nominations. There are a few things I would like to bring before the House once and for all.

"In the first place, does the Speaker of the House have to belong to the House? If Speaker Reyburn was defeated in his district, he would no longer be Speaker of the House of Representatives in Washington. Under our present system both the Speaker and Vice Speaker are not members of the House. I would like that clarified first.

"CHAIRMAN MACCORNACK: Is Mr. Crownhart here? What are the facts, Mr. Secretary?

"SECRETARY CROWNHART: Mr. Chairman, I think it is possibly within the purview of the Speaker entirely to rule on that. The secretary can state only that there is no provision in the Constitution and By-Laws which requires the Speaker or the Vice Speaker to be a member of the House of Delegates. I know of no such provision.

"DOCTOR CANTWELL: Thank you.

"The second thing is that this Committee on Nominations had a very pleasant time yesterday.

The present Speaker appeared before it in another capacity and very kindly said, gentlemen, if we placed another man in nomination it was all right with him.

"There are no personalities connected with this. I think Doctor Gundersen has a great amount of ability, but I think it is time that representatives of the Society decide who should be Speaker. This has gone on for four years. It is a matter of principle. You are not very popular when you appear against certain groups, but there is never a question of personalities. There is also a question of what is best for the state.

"The people throughout the country (and I live in a small town) say that a certain group runs the Society. Let's call a spade a spade. The Speaker of the House follows a rule of procedure that is written in his book, and whoever is the Speaker follows it. This is the same continuity of office, regardless of who is Speaker. If we are going to have the same Speaker year after year, then let's just delegate the power.

"I am also going to make the statement that I think we have the finest secretary of the State Medical Society. I have great regard for Charlie Crownhart. Our powers have been so delegated —and let's put this on paper—that we do not hire him. The Council hires him, and the Council sets his salary. It is just a delegation of power, gentlemen, and it is a matter of principle. If we are going to continue to delegate all our power, then we don't need a House of Delegates. Thank you.

"CHAIRMAN MACCORNACK: You have heard Doctor Cantwell. Is there further discussion?

"DOCTOR DREW: Mr. Chairman, may I call for the vote by ballot.

"CHAIRMAN MACCORNACK: Yes, that is required."

"Then there are statements which you might wish me to read, by Doctor Cary, Doctor Carlson, and, I believe, by Doctor Prentice, although I am not certain. Those were the remarks that were not printed in verbatim in *The Wisconsin Medical Journal* of December 1949.

It was moved by Doctors Tenney–Mason that the minutes as printed in the December 1949 *Journal*, with the addition of Doctor Cantwell's remarks, be approved as presented. The motion was carried.

It was then moved by Doctors Tenney–Cary that proceedings of the 1950 sessions be printed verbatim.

The motion was discussed by Doctor Prentice. Doctor Copps then moved, seconded by Doctor Cantwell, that the motion of Doctors Tenney–Cary be amended by adding that the "deletion of anything from the transcript be with the permission only of him who makes the remark, and that the minutes be printed and edited as they have been heretofore."

The Speaker put the amendment to a vote and it was carried.

The motion as amended was then put to a vote and was lost.

After discussion, it was moved by Doctor Copps, seconded by Doctor Berg, that "hereafter the proceedings of the House of Delegates be edited by the secretary or his assistants, as has been done heretofore, and that when the remarks of any Speaker are deleted, his permission for that deletion be secured before it is done."

There was discussion by Doctors Leonard, Farrell and Trumbo, and with the motion put to a vote, it was lost.

Dr. R. L. MacCornack, Vice-Speaker, assumed the chair.

REPORTS OF OFFICERS

REPORT OF THE SPEAKER

In the absence of Speaker Stewart, Vice-Speaker MacCornack read the Speaker's report as follows:

"According to the agenda as outlined by our secretary, the Speaker of the House is accorded the privilege of making a report.

"I am free to say that I am not so bold that I would attempt to direct your thinking or the extent or limitation of your deliberations, neither would I be guilty of condoning the interjection of controversial directives that may destroy the foundations of medicine in our state; for you, as members of the House of Delegates represent—yes, you are the foundation stone of the house of medicine —you are the law-making body, and you must preserve its freedom. It must remain democratic. It must not be subjected to directives from any source. You must be free and independent.

"However, I am bold enough to say that I should like to share with you your responsibilities and the glory (if there be such) in your accomplishments.

"On the other hand, if you are to delegate your duties and objectives to other segments of our State Medical Society, then you have become a nonentity in the affairs of medicine in our state.

"May I charge you with the responsibility of making sure that these things do not occur—that you shall continue to function as an independent and deliberative body of our State Medical Society."

On motion of Dr. M. W. Stuessy, Brodhead, seconded by Dr. T. A. Leonard, Madison, carried, the report of the Speaker was accepted.

STANDING RULES ADOPTED

On motion of Dr. H. E. Kasten, Beloit, seconded by Dr. G. W. Carlson, Appleton, carried, the following standing rules, as adopted in previous sessions, were approved for this session:

1. Without permission of the House, reports of officers be limited to twenty minutes.
2. Without permission of the House, supplementary reports of committee chairmen or members be limited to five minutes.

3. Rule 7, Roberts' Rules of Order (1915 Ed. p. 39) be modified by the provision that no member can speak longer than five minutes at a time in debate without permission of the House.
4. The Committee on Nominations shall remain in open session for one hour to hear any delegate or alternate (or other member of the Society) who may have suggestions, after which it may proceed in closed session.
5. Roll calls:
   a. An alternate delegate is alternate for a specific regular delegate and cannot serve as a "roving" alternate delegate.
   b. There is no provision recognizing bloc voting by a county society. On roll call, individual delegates or alternate delegates or specially appointed delegates will be specifically polled as to their vote.
   c. If a delegate registers but is absent for some portion of a session, his alternate delegate cannot vote. Once the delegate registers for one of the three sessions, he is the accredited representative of the county society for the duration of that session.
   d. If an alternate delegate first registers with credentials that have been supplied him, and is recorded on the report of the Credentials Committee, and some time during the course of the session the regular delegate appears, it is the alternate delegate who is entitled to vote.
   e. At the 1949 session, the House approved the motion that in order to facilitate contested elections in the future, the system employed by the American Medical Association be utilized wherein the roll call of registered delegates is called from the Speaker's rostrum, and as the name is called, the delegate or alternate comes up and deposits his ballot, so that there can be an accurate count against registration.

REPORT OF THE COUNCIL

The following report of the Council was published in the Delegates Handbook:

It is important that two matters in connection with the responsibilities of the Council be emphasized at each annual meeting of the House of Delegates. The first is that the Council is the interim body charged with administration of affairs of the Society between sessions of the House. The second is that it has been the long established policy of the Council to order detailed minutes of each of its meetings published in the *Wisconsin Medical Journal*. This provides the entire membership the opportunity to follow the work and decisions of the Council in all respects, and thus the annual report of the Council may be more a summary than a detailed report.

It seems also important to outline annually the organization of the Council. It meets on an average five times each year, sometimes more often as the occasion demands. Each month affairs of the Society are screened through the Council's Interim Committee to assure that decisions involving over-all policy are receiving careful consideration and are not unduly delayed. In addition to the Interim Committee, the Council authorizes the appointment of the following which report directly to the Council: the Directing Board of the Wisconsin Veterans Medical Service Agency; the Wisconsin Plan Committee; and committees on Audit and Budget, Open Panels, Advertising in the *Wisconsin Medical Journal*, Venereal Disease, Group Insurance, Military Medical Service, and the Coordinating Committee on Prepaid Health Plans.

Annual Meeting of Council

Under present provision of the By-Laws, the annual meeting of the Council must be held in January of each year. This was entirely satisfactory some years ago when Society affairs were less complicated, but insufficient time is now provided for closing of the financial records and the preparation of the many details which the Council must consider at the time of its annual meeting.

The Council therefore recommends that Section 1, Chapter VI of the By-Laws be amended by striking the word "January" and in lieu thereof inserting the word "February."

Auxiliary Publication

For some period of years, the Auxiliary has been provided with a page in the *Wisconsin Medical Journal* in which its activities might be recorded. Because of the many demands upon the Auxiliary for active assistance in the preservation of the voluntary forms of medical practice, it seemed to the Council that a separate publication, which could be addressed to Auxiliary members at their home address, would be desirable. This publication was authorized, and its costs do not greatly exceed the cost of providing the Journal page.

Admission to Annual Meeting

This has been a troublesome problem in so far as it relates to those within the state on a temporary basis and the like. On recommendation of the Council on Scientific Work, the Council has approved the following rules:

a. Residents—All residents, irrespective of whether they carry a resident membership, be admitted as guests of all scientific affairs of the Society (clinics, councilor district meetings, and the Annual Meeting).

b. Veterans Administration—The present requirements for admittance apply, with the exception that when a scientifc exhibit is prepared by the Veterans Administration at the request of the Council on Scientific Work, those Veterans Administration members who will be identified with the exhibit and whose presence would be desirable to interpret the exhibit be admitted as guests. This would be determined only by correspondence with the member who would be identified with the scientific exhibit involved.

c. Hospital Personnel—The present practice be followed of securing advance certification from hospital superintendents, but in cases in which the hospital superintendent fails to comply and a person presents himself or herself for admittance and can show proper identification with the hospital, such a person be admitted as a guest.

d. Others—If a physician member wishes to have his technician or office girl admitted, guest privileges should be extended upon written notice from the physician member.

Insurance Programs

The Council has followed the endorsed programs of the Society closely. The Blue Shield program is progressing well, and various administrative difficulties are being worked out as the plan moves out of its "swaddling clothes." Delegates will note from minutes of the Council that all offices of the Society have now been brought together in the State Society's building in Madison, and the Council has re-stated that the secretary of the Society is the general manager of the Society, and in that capacity responsible in detail for the operation of the Society including the employment of all personnel.

The Council, as reported to the House in 1948, has an effective committee functioning to coordinate and review activities in the insurance field. This committee, composed of particularly well informed members of the Society, is functioning most effectively. New devices, problems common to the entire membership of the Society, and other matters are constantly under its supervision and after its study, are reported to the Council for action.

Acting upon recommendation of that committee, the Council appropriated funds to retain a consulting actuary who will make detailed studies of our current programs, and will maintain those studies as the plans progress. The Council feels that this is a most significant step in the development of these plans so that physician interest and participation can be maintained, while, at the same time, providing realistic benefits to those seeking the plans' benefits.

Coordination Postgraduate Education

The Council on Scientific Work appointed a Coordinating Committee on Postgraduate Education to prepare a program of postgraduate education beginning in 1951 in an effort to develop a more comprehensive program for the physicians in the state by way of developing circuit teaching programs. These programs would extend over eight to ten weeks each year and would be coordinated with the continuation courses offered at Marquette and the University of Wisconsin medical schools. The Council on Scientific Work asked that the Council authorize the secretary's office to serve as coordinator for the expanded program in carrying out the administrative details.

The general Council of the Society feels this to be an excellent move, and one for which the Council on Scientific Work deserves high commendation. The general Council has granted the secretary's office the authority requested, and delegates and members should watch with interest as this program is developed further.

Action on Osteopaths

The last legislature with the concurrence of the officers, the public policy committee and the Council of our Society enacted legislation permitting unrestricted license to osteopaths under substantially equal education and training qualifications; schools of osteopathy must give courses similar and equivalent in quality and period of training to those given by the Medical School of the University of Wisconsin.

The legislation first introduced by the osteopaths was entirely objectionable to our group on the grounds of good methods of medical practice and the protection of the health of the public.

After long sessions with the osteopaths and their able attorney, they agreed that educational qualifications both premedical and medical substantially equal to that of students graduating from the University of Wisconsin Medical School were acceptable for an unrestricted license to practice medicine and surgery. This marked another epoch in the progress of medical care for the sick in this country. From the early days of our colonies, through the struggle to achieve national independence through pioneer development and the creation of a United States, medical practice has been varied and marked by cultism. One by one these cults have been absorbed by orthodox methods of practice as their membership has grown to professional stature. Thus the osteopath has acquired professional recognition in our state as well as in several others. Now questions of ethics are raised.

1. Should doctors of medicine respond to requests to see patients in consultation with osteopaths holding an unlimited license in an osteopathic hospital?

2. Should doctors of medicine see their own patients when taken to an osteopathic hospital in emergencies?

The only question that is above the level of trade unionism is the moral responsibility for the welfare of the sick which the physician has accepted from the time of Hippocrates. When the sick and suffering require his skill and his assistance he does not refuse.

The ethical question revolves around the adequacy of osteopathic treatment and the welfare of the patient. We cannot control the osteopath and the method of treatment which he prescribes for his patient; nor can we control the patient's choice.

Since physicians recognize osteopathy as a technic that is applicable to only one branch of medicine, physical medicine, it cannot be accepted as a system of medicine for the care of the sick.

Applicable in this regard is Chapter 3, Article 6, Section 2 of the Principles of Medical Ethics:

"A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care."

Since osteopathy is not recognized as an over-all method for treating the sick, the question here to be decided is whether adequate treatment can be admin-

istered under the circumstance. This decision is an individual one and must be made in each instance.

Chapter 2, Section 4 of the Principles of Medical Ethics, is applicable to the ethics of consulting with osteopaths in an osteopathic hospital.

"A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendent."

No rule governing all cases and no categorical statements can be made. The good judgment of the doctor of medicine and the circumstances surrounding each case must be relied upon to decide individual cases.

The Council, therefore, does not believe that a rule on the ethics of all cases can be expressed but it does wish to offer the following opinion. Invitations to consult with osteopaths holding an unlimited license should be accepted only in dire emergencies. Once the emergency is satisfied, the M.D. should withdraw from the case unless the patient expresses the desire to have the doctor of medicine continue in charge and patient is transferred to a hospital of his choice. If a patient of a doctor of medicine is taken to an osteopathic hospital as an emergency, the M.D. should treat the patient under these circumstances for the duration of the emergency.

Because the public may interpret the appearance of members of the State Medical Society on the program of osteopathic groups and societies as an endorsement of osteopathy as a system of medicine, the Council advises against and does not sanction this procedure.

Committee on Open Panels

The growing acceptance of the Open Panel program has lessened the arbitration functions of the Committee on Open Panels. During the past year only one dispute has been referred to it for arbitration. All other differences between physicians and insurance carriers have been settled without committee action.

This past year new panels for 1950–51 have been compiled and distributed. The unusual demands for additional copies indicate a growing acceptance of the program on the part of employers covered by workmen's compensation. More than 50,000 panels have been distributed to date, and new policyholders are constantly requesting panels for posting. This program has retained the physician-patient relationship to a degree not attained in most industrial health programs, and the continued support of the membership through participation helped to make it an accepted feature of the workmen's compensation program in Wisconsin.

The Conference Committee is prepared to adjust difficulties as they arise, and the inactivity of the committee bespeaks well for the program itself.

Group Insurance Study

The primary function of this committee has been achieved through the acceptance by the Council of a contract with the Provident Life and Accident Insurance Company of Chattanooga, Tennessee, providing sickness and accident coverage to members of the State Medical Society of Wisconsin based upon group participation. The eager acceptance of this program by the medical profession indicates that there was a real need for this type of coverage, and the committee feels well repaid for its efforts in obtaining a policy of outstanding merit.

One of the conditions of the contract has been that of making the Committee to Study Group Insurance in fact a conference committee, empowered to represent the State Medical Society in the arbitration of claims and to see that the insurance carrier renders service satisfactory to the policyholders. A more detailed report of operational experience will be submitted to the House in 1951.

Special Committees

During the course of the current year several special committees have been appointed with sanction of the Council to carry out specific functions assigned. The following committees are prepared to make reports:

Committee on School Health

This committee was appointed by President Truitt to supplant a former committee which was appointed three years ago to carry out a specific project and which ceased functioning at the end of one year.

The initial meeting of the Committee on School Health indicates a real need to have continuous liaison between the State Medical Society and the schools of the state. The committee has functioned essentially as an advisory committee to both the Department of Public Instruction and the State Board of Health, which two state agencies maintain separate school health divisions. There is need for close correlation of these programs and medical direction in many of their activities.

The first year of operation convinces members of the Committee on School Health that much can be accomplished by having the committee given more permanent status by becoming a recognized Council committee, with annual appointment of committee membership.

Committee on Polio Consultants

This committee was appointed by the president and approved by the Interim Committee at the request of the State Planning Committee of the National Foundation. It prepared a report which was submitted to the Planning Committee, critically evaluating the medical aspects of the Foundation program. At the request of the State Planning Committee a more specific report was prepared outlining procedures to be followed in the selection of consultants for the diagnosis of polio, and to give specialized advice in evaluating the benefits of continued hospitalization, and as the initial step of rehabilitation.

The report of this committee has been submitted to the National Foundation at the time this report was prepared. The acceptance of the recommendations by the Foundation will determine the policies to be followed in the selection of consultants. The complete report with recommendations will be made available to the membership through the *Wisconsin Medical Journal.*

The work of this committee has been of value to the profession as it crystalized in its initial report many of the criticisms the profession has offered in evaluating the medical aspects of the National Foundation. It has led to a conference with National Foundation medical personnel, and has helped to correct many procedures which have been distasteful to the medical profession in Wisconsin.

While the work of this special committee has ceased with the completion of its assignment the entire membership owes the committee a debt of gratitude in meeting a problem with courage and forthrightness, to carry to the national headquarters of the Foundation some constructive criticisms of the program as it has been carried on in Wisconsin.

Medical Care Survey Committee

The 1949 House passed a resolution suggesting a statewide study to determine the effectiveness of medical care programs to meet the needs of the citizens of Wisconsin, particularly those engaged in industrial activity. The committee appointed to carry out this assignment has spent considerable time and thought on how the objective might best be achieved. It was finally decided to conduct a pilot study in one representative county, to see what pattern for further study might be attained. At the present time an intensified study is being made in Rock County, and it is anticipated that before the next session of the House the findings of this survey and similar studies in other parts of the state will give the Society some of the answers suggested in the resolution passed in 1949.

This committee suggests that it be continued for another year, at which time it will be prepared to make a more specific report to the House

Report on Necrology

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by bold face type.

Baasen, J. M.
_____ Mount Calvary
Baird, Katharine
_____ Wauwatosa
Bangsberg, S. G.
_____ La Crosse
Binneweis, F. C.
_____ Orlando, Florida
Blackburn, F. E.
_____ Cassville
Boren, J. W. _ Marinette
Boslough, A. W. Wausau
Cahoon, Roger _ Baraboo
Carlton, E. P.
_____ De Forest
Carson, A. W. _ Niagara
Christensen, O. A.
_____ Hawkins
Clifford, P. M.
_____ Green Bay
Currer, P. M.
_____ Milwaukee
Dieterle, J. O.
_____ .Milwaukee
Dike, C. E. _ Whitewater
Dodd, J. M., Sr.
_____ Ashland
Doyle, J. H.
_____ Little Chute
Echols, C. M.
_____ Milwaukee
Fay, Ella C. Whitewater
Ford, W. B. _ Milwaukee
Geisse, C. E.
_____ Fond du Lac
Green, M. K. __ Madison
Greenthal, R. M.
_____ Milwaukee
Greund, W. E. _ Superior
Grover, F. L. _ Hartland
Hager, F. J. __ Denmark
Halsey, R. C.
_____ Lake Geneva
Harlow, G. A.
_ Winter Park, Florida
Hoel, K. P.
Battle Creek, Michigan
Judson, D. E. Janesville
Kincaid, J. H. _ Chicago
Kolter, J. H. ___ Wausau
La Breck, F. A.
_____ Eau Claire
Lemmer, G. N. Madison
Leonard, E. T.
____ Rockford, Illinois
Looze, J. J.
____ Wisconsin Rapids
Lueck, G. W.
_____ La Crosse
Malloy, T. E. Milwaukee
McCarty, E. O.
_____ Chippewa Falls
McGrath, E. F. Appleton
Neff, E. E. ____ Madison
Nugent, A. C. Milwaukee
Pegram, J. W.
_____ Milwaukee
Quinn, R. B. _ Darlington
Reese, William
_____ Dodgeville
Rehorst, J. J.
_____ Fond du Lac
Russell, F. H. __ Tomah
Rust, E. A. _ Milwaukee
Schlossman, N. C.
_____ Waukesha
Schnetz, L. N. __ Racine
Schodron, R. C.
_____ Milwaukee
Schoofs, O. P. Milwaukee
Schroeder, J. C.
_____ Milwaukee
Schuldt, M. M. Platteville
Shauger, L. S. __ Ogema
Simon, L. J. Fond du Lac
Smith, E. V.
_____ Fond du Lac
Smith, H. S. ___ Cudahy
Smith, S. M. _ Milwaukee
Swartz, K. A. _ Waupun
Teich, W. E. _ Milwaukee
Truesdell, C. M.
_____ Taylors Falls
Tucker, I. N. ___ Racine
Unkirch, C. R.
_____ Whitewater
Van de Erve, Walter
_____ Milwaukee
Van Altena, L. A.
_____ Cedar Grove
Waite, W. S. Watertown
Whiffen, R. A.
Willow Glen, California
Wochos, W. M. Kewaunee
Zuercher, J. C.
_____ Milwaukee

SUPPLEMENTARY REPORT OF THE COUNCIL

Dr. R. G. Arveson, Chairman of the Council, Frederic, asked that Secretary Crownhart present the Supplementary Report of the Council, which included the following material published in the November *Journal,* with the Council minutes of September 30 and October 1:

- The Report on the Pharmacy Law
- Advisory Commission, Prepaid Health Plans
- Determination of Income under Prepaid Plans
- Remission of Dues for Members in Service
- Resolution Commending the Radio Stations Carrying the March of Medicine
- Resolution Commending Newspapers of the State
- Resolution to Provide for Minimum of Five-Men Committees
- Resolution on Malpractice Insurance Study
- Resolution on Hospital Standardization
- Special Report on Health Insurance Plans in Wisconsin

In addition, the report of the Committee on Military Medical Service and a proposed amendment with regard to membership in the American Medical Association were included as follows:

Committee on Military Medical Service

Two years ago, at the request of this committee, the House of Delegates passed a resolution calling the attention of the governor of the state of Wisconsin to the need for the establishment of an adequate program of civil defense for the state. Legislation introduced in the 1949 session of the legislature was not enacted, but sufficient interest was aroused so that voluntary and governmental groups are preparing to act.

The committee felt the matter of disaster preparedness for either war or natural disaster so pressing that it went ahead with the development of a program to provide adequate medical care in event of any state emergency. The House of Delegates had requested every county society to establish a committee on military and disaster medical service. Thirty-two county medical societies have set up separate committees dealing with this phase of medical care, and other counties handle the matter through the officers or other committees.

Under the direction of the committee these societies have been conducting surveys of ambulance facilities, existing hospital beds and proposed emergency bed capacity along with other factors.

Because every disaster has certain foreseeable results, the committee has made preliminary plans which should enable the medical profession to respond to an emergency with maximum effect and the least possible delay and confusion.

It has developed a "Civil Defense and Disaster Medical Service Plan" which recognizes that local self-help is the first requirement of a good disaster plan. The plan provides for the mobilization of all medical personnel and supplies and the organization of mobile "disaster units" in each county society, capable of going to the aid of stricken areas anywhere in the county or if necessary, in the state. These disaster units include teams of physicians, nurses and aides for collection of casualties, first aid, evacuation, field surgical services, field medical services, supply, disposal of the dead, and provision of drugs, blood, water, tentage, ambulances, and assistance from allied professional personnel and local volunteers.

Within the past two months, the governor has appointed Col. Ralph J. Olson, Madison, as director of state civil defense. Dr. Carl N. Neupert, state health officer, has been named director of health services in the civil defense setup. The committee has assured the director of civil defense and the director of health services that it has the complete cooperation of the medical profession which will give every possible assistance in the development of effective medical and health services in the civil defense program.

Earlier this year, prior to the appointment of a civil defense director, the committee made several proposals to the Adjutant General's office which had been designated to handle civil defense temporarily. The committee recommended that:

1. Appropriate legislation, including proper authority and funds, be obtained as quickly as possible to permit establishment of an adequate civil defense program.
2. A state guard be established, not primarily to bear arms, but to act as civil defense unit for the handling of disasters and emergencies.
3. At least one, and possibly three, fully equipped medical units comparable to those of a medical battalion in the National Guard be an integral part of any State Guard that is set up.
4. Two complete 750-bed evacuation hospital units with field equipment be consigned by the United States Army to Wisconsin to be available to the National Guard or the State Guard in an emergency.

The Adjutant General's office has since replied favorably on each of the four recommendations.

Proposed legislation has been drafted by the Legislative Council for introduction when the legislature convenes in January, 1951. Provision is being made for the establishment of a State Guard with "mobile reserve battalions" for disaster relief function, and thought is being given to three self-sufficient medical units as part of the State Guard. Investigations are under way through the Adjutant General and the Council on National Emergency Medical Service of the American Medical Association to determine how the state may acquire the two 750-bed evacuation hospitals.

By your direction, the committee has taken over the responsible, and sometimes complicated, task of advising the Wisconsin Military District and Fifth Army Headquarters as to the availability of Army medical corps reserve officers for extended active duty. This assistance is being given the Army in order that reserve officers from Wisconsin may have assurance that they will be called to duty on a priority that is, in so far as possible, equitable and fair under the categories established by the Department of the Army.

The files maintained and supplemented by the committee since the end of World War II are now proving invaluable. Additional information has been obtained by special questionnaires, and a large volume of letter, telephone and personal contacts has become necessary. The Wisconsin Military District and Fifth Army Headquarters have demonstrated a fine spirit of cooperation, and the committee is making every effort to follow a policy that will be fair to both the reserve physician and the military.

The committee is aware that the close cooperation existing between the State Medical Society and the Army Reserve has not yet been established between the Society and the Navy or the Air Force Reserves. The Navy has not seen fit to consult

with the Society concerning reserves it is calling from Wisconsin. While the committee recognizes the military's prerogative to call its reserves without advice or consultation from any civilian source, it believes that the national health and safety as well as the individual reservist's position are endangered by uncoordinated and unadvised call-ups of reserve officers. The committee recommends that the American Medical Association through its Council on National Emergency Medical Service immediately seek a commitment from the Navy and the Air Force regarding their willingness to consult with local medical authorities before calling reservists.

Considerable thought is being given to the entire matter of the calling of reserves and non-reserves as it will be affected by the recently signed "doctor draft" law which provides for registration of all physicians up to the age of 50 years. The committee understands that the law is intended to bring to duty first those individuals who have seen no service, this probably to include those who have been trained at government expense. Reservists are to be called to active duty as needed on priorities like those in the draft law.

This the committee believes to be a commendable policy since its effect is to delay the calling of doctors in the reserves who, in many instances, already have seen many years of active duty and now have essential civilian posts.

Selective Service indicates that state medical societies will be asked to help determine the availability of physicians under the law, but to date no specifics have been announced. The committee believes it highly important that the American Medical Association take steps to insure that special mechanisms will be set up at an early date so that thorough understanding of policies and procedures is achieved before the full pressure of selective service is upon the profession. Such mechanisms, whether they be a separate agency such as the Procurement and Assignment of World War II or a new plan, should provide the means to consider each doctor's availability with fairness to actual civilian and military needs.

Proposed Amendment

Re: Membership In American Medical Association

WHEREAS, the American Medical Association has through the years provided much of the leadership and the initiative for raising professional and public health standards at the national level, and

WHEREAS, the American Medical Association is a federation of the state medical societies, and required that its members also be members in good standing of their respective state societies, and

WHEREAS, it is believed that the principles of unity and cohesion should operate throughout the structure of organized medicine

Be it therefore resolved that this House amend Section 1, Article IV of the Constitution to read:

"This Society shall consist of members who shall be the members of the component county medical societies, and, *who shall also be members in good standing of the American Medical Association*, and who have been certified to the headquarters of this Society, and *all of* whose dues and assessments for the current year have been received by the secretary."

NOTE: *New wording underlined above*

REPORT OF THE PRESIDENT

PRESIDENT J. W. TRUITT: Mr. Speaker, members of the House, and guests: In the last number of *The Wisconsin Medical Journal* I thanked you for making this past year pleasant and constructive. Without your help and the help of the citizens of Wisconsin, the president would be only a figurehead.

The various problems which have confronted your Medical Society, and the attempted solutions, are recorded in the State *Journal*. This does not give a true picture of the time and energy spent by your officers, the Council, the Interim Committee, and other committees; and if this job has seemed at times to demand too much out of each and every one of us, then the jobs performed by the secretary and his personnel have been beyond the call of duty.

One of the brightest spots of the past year has been the health and accident program. On September 15 more than a majority of the physicians in active practice were enrolled. All the insurance companies doing business in this state were invited to bid for this business, continuing the American way of doing business. Past President Karl Doege and Dr. Maurice Hardgrove's committee are to be congratulated.

All the other committees have given freely of their time and thoughts. The state has had a Grievance Committee for some years. Last year this committee was enlarged for geographic reasons. I have sat with this committee, and cannot praise its handling of complaints too highly.

I will also say that the State Auxiliary will be thanked by me in person for its splendid work and cooperation. The Auxiliary is a very important part of the medical organization. I do not believe any doctor could be president of this organization for one year without forming some ideas about its functions and its numbers.

One of the things which has been most difficult for me to understand is the criticism of members about various problems, and then their absolute apathy when given a chance to work and study and try to help solve the things they criticize. We had this happen on the questionnaire about the fee schedule.

The major observation of this past year is that there are no problems which face the medical profession which cannot be solved by the American way, voluntarily, in an orderly, progressive, majority-rule manner.

The main objective of the medical profession should be that of being ardent citizens. Exercise your franchise. You are among the groups that should be leaders. You are able to examine your patients and arrive at a diagnosis. Do the same with the candidates.

The scientific endeavors will all be in vain if freedom is lost. If we go down the socialistic road all the rest will follow, as history is proving.

I should like to take one more minute of your time. It probably seldom happens to a president of this organization to have among the personnel an individual who has sympathy, understanding, and everything that goes with it, to the extent that when one of the top jobs in the United States is offered to him, after due consideration and study he decides, because of his love and his faith in the medical profession, to stay with us.

I thank you.

INTRODUCTION OF GUESTS

Vice-Speaker MacCornack introduced Dr. Elmer L. Henderson, Louisville, Kentucky, president of the American Medical Association; Dr. George F. Lull, secretary of the American Medical Association; Dr. W. S. Jones, Menominee, Michigan, councilor of the Michigan State Medical Society; and Dr. Frank Elias, Duluth, Minnesota, president of the Minnesota State Medical Association.

ADDRESS OF DR. ELMER L. HENDERSON

Mr. Speaker, members of the House of Delegates of the State Medical Society of Wisconsin: It is a distinct pleasure and a great honor for me to be here with you this afternoon. I am very grateful for the invitation to attend your meeting, and I hope to be here for the next two days. I know that I am going to enjoy myself here with you.

You know, you of Wisconsin have one of the leading state societies in the United States. There are some societies that are outstanding; there are other societies that are mediocre, and I know that you realize it, the same as we have outstanding men in medicine—men who are really interested in the affairs of medicine, and men who are willing to spare their time and work for the good of medicine. That is what it takes to make up a good state medical society, and that is what you have here in Wisconsin.

I have had the pleasure of attending a great many state medical society meetings in the past year, and I know what some of them are doing. I had the pleasure just two weeks ago of attending the Michigan State Medical Society meeting. They have a wonderful group up there. They have an outstanding group, the same as you have here. The same is true of Indiana. They have a group that is really going out and doing things. Gentlemen, that is what we have got to have in this country if medicine and freedom in this country are to survive.

You know, you have some wonderful leaders in Wisconsin. I have had the pleasure of knowing some of them for quite a while. When I first came on the Board of Trustees of the American Medical Association, our president at that time was from Wisconsin—Dr. Rock Sleyster. I am sure you all remember him. He did a wonderful job for organized medicine.

You have today in the House of Delegates three outstanding men, three strong men of medicine—Steve Gavin, Bill Stovall, and Jim Sargent. They are all doing a marvelous job in the House of Delegates of the American Medical Association.

You have another man whom I did not know until about two years ago. Two years ago in June Gunnar Gundersen was elected to the Board of Trustees of the American Medical Association. I had never met him previously, although he had served in the House of Delegates previously, but had dropped out.

The first time I had the pleasure of meeting him was the afternoon he was elected a trustee of the Association at the organization meeting. I happened to be chairman of the Board of Trustees the first year Gunnar was on the Board, and he came to the meeting and sat around and observed everything; and he kept pretty quiet. Finally, we began to realize that he was taking note of everything—and I want to tell you that today Gunnar Gundersen is one of the strong men in American medicine, and he is doing a real job on the Board of Trustees of the American Medical Association.

I served two terms on the Board of Trustees, and during that time no man ever came to the top like Gunnar Gundersen did. Gunnar today is chairman of the Executive Committee of the Board of Trustees, and also chairman of the Finance Committee. When something important comes up for which we need a strong man, we look to Gunnar Gundersen. I thank you, gentlemen, for picking out such an outstanding, strong man as Doctor Gundersen.

Another thing I want to congratulate you upon is your executive secretary. I have an idea that in the closing remarks of your president, a few minutes ago, he was referring to Charlie Crownhart. Charlie Crownhart is one of the strong executive secretaries of any state society in this country. Some of the executive secretaries do not seem to get the viewpoint of the doctor, and some of them do not get along so well. Some of them do not please the profession as well as others do.

I want to tell you that Charlie Crownhart is a man of whom you should be very proud. I know there are people who would like to have him in other high positions. I know that personally, and I just want to pay that tribute to him.

Gentlemen, American medicine is at the crossroads today. We either go forward from here on, or we go backward. If there was ever a time in American medicine when the profession as a whole should be united, it is now. I am positive that there is more unity in the medical profession throughout this country today than ever before in the history of American medicine—no question about that.

Still we do not have entire unity. We have bickering in some of our local organizations and in some of our state organizations. It seems difficult, sometimes, for one group in a state organization to understand another group, and it seems difficult

to get together and to pull together. It is the same in the American Medical Association.

Gentlemen, this is still a democratic country, and that is what the doctors are devoting themselves to today—to keeping it a democratic country. We must be democratic in our own organization. When the majority says "This," "this" is what it should be, and everybody should get in and push and try to make it go.

There has been a lot of dissatisfaction in some states in regard to prepaid medical insurance plans. That is something that cannot please everybody; but if the majority wants a certain plan, it behooves us all to get back of that plan in that locality or state and see if they can make it go. Now is no time to rock the boat. We must all get together and really have unity.

A lot of us go about over the country, in medicine and in other walks of life, preaching the American way of life, talking for unity throughout our country, and talking against state socialism. Gentlemen, I want to tell you that it is later than some of you think. We have gone a long way down the road to state socialism.

I have confidence enough in the medical profession of this country to know that they will stop it. The American Medical Association has stepped out and is now a crusading organization for the American way of life today. Our doctors throughout the country are following through and are doing a job throughout the country.

We as an organization, and you as an organization, cannot become active in politics, but at the same time you are private citizens of your state and the United States, and as such you can get out and form committees and work for the men you know are interested in keeping this country a free nation, and fighting for the principles that our fathers fought for and bled for.

Gentlemen, that is what the American Medical Association and what your Association, and what all associations, in and out of the medical profession, should be doing today. Thank God, I think the time has come when the American people have become aware of the fact that we are in danger.

Certainly we are all for fairness throughout this country; but we are drifting, gentlemen, in the direction of state socialism. I want to tell you that if you are not on your toes, and if you are not aware of where we are going, you had better be thinking about it.

I have had the opportunity, during the past three years, to visit Britain seven times. I visited all of the countries in Central Europe, those outside the Iron Curtain, and I have been in the Orient and down through South America. I have traveled pretty extensively in the past few years, and I know what socialism is like. I know what it brings to the people.

You know, there are people who would like to level you off, to put everybody on one level, and when they do that they realize then what a mistake it is. The man who earns $3,000 in Britain today pays eleven times the visual taxes that the man pays who earns the same amount in the United States. We pay enough taxes in the United States. In addition to that, the taxes on luxuries and food and everything else are way out of proportion to what we pay. That is what we are drifting toward, gentlemen!

You have your problems in Wisconsin, and we all know it. I know that you are going to cope with them.

Doctor Lull also addressed the House briefly.

REPORT OF THE PRESIDENT-ELECT

The report of President-Elect Christofferson was published in the November issue of *The Wisconsin Medical Journal*. His committee appointments are contained in the October Medical Forum section of *The Journal*.

Under provisions of Chapter VII of the By-Laws, committee appointments are made by the incoming president, by and with the consent of the House. On motion of Dr. J. H. Robbins, Madison, seconded by Dr. J. W. Fons, Milwaukee, carried, the committee appointments were approved.

REPORT OF THE TREASURER

REPORT OF DR. IRA R. SISK, TREASURER, FOR THE YEAR ENDED DECEMBER 31, 1949

Cash on Deposit—First National Bank, January 1, 1949		$ 1,647.72
Receipts		
Membership Dues	$135,530.54	
1949 Exhibit Space Rentals	10,992.50	
Panel Receipts—Wisconsin Plan	512.50	
Round-table Receipts	3,664.00	
Postgraduate Clinic Receipts	3,014.25	
Interest Received	183.96	
Principal Collected on Aetna Insurance Policy	1,004.40	
Partial Payment of Advance—Wisconsin Veterans Medical Service Agency	7,500.00	
Total Receipts		162,402.15
Total		$164,049.87
Disbursements		
Constitutional Officers and Committees		
President	$ 500.00	
Council and Committees	9,763.74	
Books and Periodicals	901.35	
Auxiliary	200.00	
Secretary's Salary	12,500.00	
Secretary's Travel	2,873.88	
Group Total	$ 26,738.97	
Organization—Staff		
Assistant Secretary's Salary	$ 8,400.00	
Assistant Secretary's Travel	951.46	
Executive Staff	14,883.00	
Group Total	$ 24,234.46	
Administrative Expenses		
Accounting and Insurance	$ 4,030.37	
Social Security and Unemployment Compensation Taxes	909.10	
Office Rent	4,200.00	
Telephone and Telegraph	1,556.87	
Current Supplies	2,033.81	
Postage and Printing	4,580.78	
Fixtures and Upkeep	1,061.17	
New Equipment	2,379.69	
Miscellaneous	1,409.05	
Group Insurance	371.70	
Group Total	$ 22,532.54	
Totals—carried forward	$ 73,505.97	$164,049.87

Totals—brought forward	$ 73,505.97	$164,049.87
Membership—Special Service		
Legal	$ 2,544.50	
Bulletins to Members	431.02	
Blue Book Issue	750.00	
Group Total	$ 3,725.52	
Public Health—Normal Service		
Hygeia	$ 316.25	
Lay Publications	31.74	
Special Bulletins	327.79	
Telephone and Telegraph	264.14	
Legislative Counsel	2,000.00	
Veterans Medical Care and Prepaid Medical Care Plans	5,134.49	
Group Total	$ 8,074.41	
Public, Industrial and Rural Health and Public Instruction		
Wisconsin Plan Director	$ 1,200.00	
Executive Director—Public Information	5,200.00	
Staff Salaries	5,294.38	
Executive Director and Staff Travel	1,903.90	
Press Releases	562.09	
Radio Programs	4,730.18	
Industrial Panels of Physicians	1,251.08	
Miscellaneous	268.51	
Group Total	$ 20,410.14	
Annual Meeting, Postgraduate Clinics, County Medical Research Projects, and Wisconsin Medical Journal		
Annual Meeting	$ 15,008.88	
Postgraduate Clinics	3,549.45	
County Medical Research Projects	254.50	
Wisconsin Medical Journal	2,500.00	
Group Total	$ 21,312.83	
Other Expenditures		
Interim Appropriations	$ 6,566.57	
Appropriations to State Medical Society of Wisconsin—Building Fund	10,040.72	
Appropriation to Secretary's Working Fund	500.00	
Group Total	$ 17,107.29	
Total Disbursements		144,136.16
Cash on Deposit—First National Bank, December 31, 1949		$ 19,913.71

Dr. P. B. Mason, Sheboygan, inquired whether the details of sums expended for prepaid health care plans could be explained. The treasurer stated that details were in the Madison office but that the secretary would furnish them to Doctor Mason.

Doctor Sisk supplemented his report by the following statement:

"At the time of the meeting of this body, when the dues were established for the year 1949, it was directed that an amount which, I believe, was $5 per member, be set aside for investment purposes. When this report was made out that had not been taken care of, but since then I have purchased government bonds in the amount of $14,000.

"It should be known by all of you that during the course of the year many doctors asked me what the size of the mortgage was on our home in Madison. It has been said before that there is no mortgage. The house is paid for, the remodeling is paid for, and the furnishings are paid for."

REPORT OF THE SECRETARY

The following report of the secretary was published in the Delegates' Handbook:

The year 1950 has brought an increased tempo to the administrative side of the Society never contemplated a decade ago. Part of this results from the volume of inquiries and problems arising out of the prepaid plans and the fact that the Society now operates in fields of direct economic impact to its members.

The American Medical Association and its revitalized program with respect to insurance by compulsion have resulted in voluminous activity in state offices. In recent months, speakers have been assigned to engagements in practically every area of the state. Many thousand leaflets and other explanatory material have been distributed to various lay organizations and persons. Local organizations in other fields have entered into medical economic discussions, and the consequence is that Wisconsin ranks well in the number of organizations on record in opposition to the Truman–Ewing proposal in the field of compulsory sickness insurance.

These two developments in themselves have been carried on in Wisconsin without appreciable slackening of efforts in other directions. Reference to the various committee reports should be indicative of that fact.

The special 1949 assessment of the American Medical Association was paid by 2,268 of the membership of the State Medical Society, and 2,725 were classified as full dues-paying members. It is obvious that the response from the membership was excellent.

The 1950 membership status, as of August 14, 1950, stands as follows:

Life Members	80
Honorary Members	9
Resident Members	180
Associate Members	9
Affiliate Members	63
Full Dues Members	2,565
who paid both state and A. M. A. dues as 8/14/50	
Total in compliance with all requirements as of 8/14/50	2,843
Members who refused or failed to pay A. M. A. dues, although paying state and county dues	122
Total number delinquent at the date of this report	196
(this total includes 7 members who were voted to associate membership)	

There are still 10 members whose status is pending.

One member is making partial payments.

As in other years, the secretary emphasizes that it is the work of the various committees, the Council, the House of Delegates, postgraduate clinics, publicity, the *Wisconsin Medical Journal* and the like which reflects the administrative activities of the office. Routine matters seldom come to the attention of the members. The clerical activities and organization work involved in handling membership problems, the multitude of details that arise in connection with the prepaid plans—these and other matters occupy the staff with little surcease.

The secretary is grateful to the Council and the membership for their willing response to the problems of administration. The Society possesses a record of achievement and a program of which it may well be proud.

In addition to the report of the secretary, published in the Delegates' Handbook, Secretary Crownhart stated that the staff of the State Medical Society and its agencies, the Veterans Agency and Wisconsin Physicians Service, now totals 34 and is cooperating splendidly in the interest of the Society and its members.

He also paid tribute to Treasurer Sisk as one of the unsung heroes within the framework of the State Medical Society, and for his voluminous task as watchdog of the treasury.

The supplementary necrology report since publication in the Delegates' Handbook was presented as follows:

Members of the Society:

Gideon Benson, Richland Center
L. A. Campbell, Sr., Clear Lake
Burton Clarke, Oshkosh
I. G. Ellis, Madison
A. S. Pfeiffer, Racine
August Sauthoff, Madison
F. E. Turgasen, Manitowoc
L. A. Vander Linde, Milwaukee

Non-members of the Society:

C. H Dodge, Clinton
W. F. Petersen, Lake Geneva
C. J. Rollefson, Superior
G. F. Ronneburger, Milwaukee
T. R. Spears, Washburn
E. A. Wright, Lakewood City, California

Members of the House of Delegates stood in silent tribute to the memory of the deceased members and non-members.

EXCERPTS FROM ADDRESS OF PRESIDENT OF WOMAN'S AUXILIARY

Mrs. C. N. Neupert, *Madison:* Our greatest objective was the education of the public against any form of compulsory health insurance. We first planned an extensive "self-education" program. Many auxiliaries formed study groups, using the splendid outline prepared by Mr. Earl Thayer, of the State Medical Society office. In our personal campaign we have been able to influence public opinion by explaining voluntary versus compulsory health insurance.

All of our larger counties have had open meetings, to which were invited representatives of the various clubs, business, and labor organizations. Speakers for these meetings were either from the State Medical Society, the Speakers' Bureau, or were local doctors. Their presentations had to do with the American Medical Association's position on the issue. We were also very fortunate in having Mrs. Robert Fitzgerald, one of our own members, speak to many auxiliaries and lay groups throughout the state.

These meetings all received publicity in the local newspapers, and we feel we have made a good beginning for the coming American Medical Association newspaper campaign.

To be effective in advancing our cause we must have an active interest in others. The members of the Auxiliary have stepped out into the community, and ours has become known as an organization interested in all activities regarding the health of its people. We have been busy constantly in fund raising for the Cancer Society, the Tuberculosis Association, the National Foundation for Infantile Paralysis, the Heart Association, and many others.

We have assisted in the organization of blood banks, cancer clinics, and hospital auxiliaries, giving many hours of service to each group. In these and many other phases of medical service the Woman's Auxiliary, in its unobtrusive but effective way, has been able to help turn the tide.

Our Auxiliary members all are members of other clubs. It is through these channels that we have made our influence felt. We have distributed literally tons of literature to the PTA groups, League of Women Voters, both Republican and Democrat clubs, church and school organizations, university and state women's clubs. We have placed many speakers on medical topics on the programs of these groups.

We have continued to sponsor nurse recruitment. Milwaukee County has again given two scholarships, and many of our members have given talks to senior high school girls urging them to take up nursing as a profession.

In the matter of legislation, nothing has been done without the approval of the chairman of the Council or the secretary of the State Medical Society.

Throughout the year letters were sent by the legislative chairman urging the membership to write to their congressmen, in favor of or against the various bills of interest to the medical profession.

The Auxiliary wishes to thank the Council for making possible the publication of our new bulletin. Every member will receive a copy four times a year. It will be a great help in the coordination of our program. May I suggest you make use of the "Badger Doctor's Wife" if you have a message for the Auxiliary.

We also wish to thank Mr. Crownhart and his staff for their 100 per cent cooperation with us. It is this sort of help, and the enthusiasm of so many public-spirited Auxiliary members, that has made the past year pleasant and, I hope, effective in Auxiliary work.

EXCERPTS FROM REPORT OF STATE HEALTH OFFICER

Dr. C. N. Neupert: Our most urgent common concern today is for civil defense. First of all, there is the best of cooperation and coordination between the Health Services Division, in my charge, and in the State Civil Defense setup and our State Society Committee on Military Medical Service, under the chairmanship of Dr. F. L. Weston.

Your committee recognized two years ago the seriousness of what we face. Five hundred city and state officials from 20 states spent five days in Chicago the end of September, going over Chicago's plan for this serious emergency. Chicago has been working hard for the past year, having started in 1947.

Responsible citizens, non-military, regard the prospects very seriously.

"Civil defense" means just that. It is based on civil government this time, civil control by cities, and self-help. In other words, you start at home, plus mutual aid from others when you cannot carry it by yourself.

Chicago looks to Indiana, Michigan, and Wisconsin to come to its aid in a major catastrophe if it cannot handle it alone; and from the exercises that we went through in Chicago last week, when they had a hypothetical bombing of Chicago with three atomic bombs dropped, gentlemen, they needed the help of the surrounding areas, and it was not considered improbable or impossible.

Milwaukee is Wisconsin's number 1 military target. Other cities also are possibilities. Bombs other than A-bombs may be involved. This is now being referred to as A–B–C warfare—atomic, biologic, and chemical warfare.

We can reduce nonfatal casualties 75 per cent providing we are ready, and if those casualties involve as many as 60,000 dead in one hit, with 80,000 casualties, a little arithmetic will tell you that 60,000 people may be dying needlessly.

Cities are working out their own plans. This takes a tremendous amount of work. It may be later than we think.

First, find out your resources. Second, perfect your plan. That takes hours and hours and weeks of work. Here in Milwaukee meetings have been held every week for nearly a year; lately I understand they have been held every two or three weeks.

Third, train and rehearse. If you do not train, you are going to make some terrible mistakes.

Streets have to be open so we can get in. Everybody will want to use the communications systems. Everybody will want to telephone to his various deputies and families. If there is no planning, there will be no chance. Radio and other public phases will have to be coordinated.

The British are sharing their experiences and knowledge with us. There were two Britishers with us in Chicago. Some of our own men have been there and have gone through training with them. They are very serious about this. They have been through it, and they say planning is the only way that it can be handled.

Where are we? Milwaukee has one of the country's best plans. Some other cities in Wisconsin are getting started.

So far, 26 of the county medical societies have responded to the questionnaires that Doctor Weston and his group sent out for emergency hospital beds. Additional beds that could be used in schools and churches, and so on, have actually been hunted out. There must be places where patients can be taken care of, and they must have water and food, also ambulances; four physicians who will be atomic energy instructors in Wisconsin have been selected and have attended a one week course in Chicago, one representing Marquette; one, the University of Wisconsin Medical School; one, the State Medical Society; and one, our department. Three of them attended the course, and the fourth man was unable to do so at the time.

In some small communities there is practically no likelihood of direct involvement by bombing. However, if we are going to swing this, they may need us all. I cannot say that too strongly.

I have set up an Advisory Committee to the Health Service on a state level. Ten state organizations have been asked to name their own representatives. We meet on October 2 for the first time, and of course probably the most important member of that Advisory Committee will be the representative of the State Medical Society. We will need area deputies for coordination.

First, accept the extra load of civil defense, whatever is required. Get into it! It's not just folderol. Start studying. Attend classes of atomic warfare; be ready to spend hours planning jointly with others.

For instance, the fire-fighting, police control of streets, clearance, communications, and so on, have to work together. There will be no grand opening up for us just to take over and everybody else step aside.

Recess

The House of Delegates recessed at 5:30 p.m. for a buffet dinner and reconvened at 6.35 p.m.

SUPPLEMENTARY REPORTS AND RESOLUTIONS

Dr. B. J. Hughes, Winnebago, presented five resolutions on insurance introduced at the request of the Wisconsin Chapter of the American Academy of General Practice as follows:

Resolutions on Insurance

WHEREAS the multiplicity of prepaid insurance plans within our state has resulted in a confusion to the physician and the people, and

WHEREAS the Wisconsin Plan was given the endorsement of the House of Delegates in 1945 as a one-year experiment and,

WHEREAS it is the feeling of many of the physicians of the state that the control of the fee schedule should rest with physicians alone,

Therefore be it resolved that the House of Delegates rescind its endorsement of the Wisconsin Plan.

WHEREAS the fees paid by Wisconsin Physician Service are at times found to be inadequate, and,

WHEREAS the fee schedule of Surgical Care of Milwaukee County offers a much higher fee schedule for difficult procedures, and

WHEREAS both plans are quite identical in their structure and operation,

Therefore be it resolved that the House of Delegates instruct the operating committee of Wisconsin Physicians Service to change its fee schedule to compare with that of Surgical Care.

WHEREAS Wisconsin Physicians Service and Surgical Care were created to offset the catastrophic cost of illness and to provide a means of prepaid

health insurance to the people of Wisconsin in the lower income group, and

WHEREAS a large segment of the rural population has yet to benefit from these plans,

Therefore be it resolved that committees representing Wisconsin Physicians Service and Surgical Care be created to confer with a committee representing the Blue Cross plan to the end that the self-employed can obtain the same benefits as the employed groups.

WHEREAS Wisconsin Physicians Service is presently being offered to the people of Wisconsin in all counties throughout the state with the exception of Milwaukee County, and,

WHEREAS Surgical Care is being offered the people of Wisconsin only in Milwaukee County and not in the other counties of the state, and

WHEREAS it has often been stated that competition is a healthy element,

Therefore be it resolved that the House of Delegates recommend that both Wisconsin Physicians Service and Surgical Care be sold throughout the entire state.

WHEREAS in many instances the immediate care of minor injuries, such as certain fractures, lacerations, and minor amputation could well be done including x-ray study in the physician's office, and

WHEREAS transfer of patients to the hospital adds to the time and cost of the procedure,

Therefore be it resolved that the House of Delegates instruct the operating committees of Wisconsin Physicians Service and Surgical Care to allow full coverage for these types of procedures whether hospitalized or not.

In the absence of Dr. A. A. Cantwell, Shawano, on motion of Dr. F. E. Drew, Milwaukee, seconded by Dr. K. G. Pinegar, Marinette, carried, the secretary was asked to read the following resolutions submitted by Doctor Cantwell:

A Resolution Creating a Section on Obstetrics and Gynecology of the State Medical Society of Wisconsin

Be It Resolved, that the House of Delegates create a Section on Obstetrics and Gynecology within the State Medical Society of Wisconsin, such action being take under the provisions of Chapter XII of the By-Laws.

Be It Further Resolved, that the formal organization of this section, including the election of officers and a delegate, shall be taken during the course of the 1950 Annual Meeting.

A Resolution Relating to Amendment of the By-Laws to Require That Those Candidates for the Offices of Speaker and Vice-Speaker of the House of Delegates be Members of the House and Classified as Full Dues-Paying Members.

Be It Resolved, that Chapter IV of the By-Laws, relating to the election of officers, be amended by adding Section 6 thereto reading as follows:

Section 6. Candidates for the office of speaker and for the office of vice-speaker of the House of Delegates shall be members of the House of Delegates either as delegates or alternate delegates from component county medical societies. Such candidates shall also be full dues-paying members of the Society.

On motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. J. Holden Robbins, Madison, carried, the House consented to the presentation of the following resolution by Dr. W. T. Clark, Janesville, which was not read in full inasmuch as it was printed in the Delegates Handbook:

A Resolution Regarding Adoption of Hess Report by the A.M.A. House of Delegates, June 1950, Meeting in San Francisco

WHEREAS, the House of Delegates of the American Medical Association in assembly at San Francisco, California, June 28, 1950, adopted the report of the Reference Committee on Reports of Board of Trustees and Secretary, section thirteen of which contained the report of the Committee on Hospitals and the Practice of Medicine (Hess Committee), and

WHEREAS, the report recommended that each component state or territorial society appoint a Committee on Hospital and Professional Relations to receive, hold hearings upon, and adjudicate all complaints relating to professional and/or economic problems involving physicians and hospitals, and

WHEREAS, the State Medical Society of Wisconsin has for nine years had a standing Committee on Hospital Relations which has heretofore confined its activities and efforts to promoting the development of mutual understanding and amity between representatives of medical organizations and hospital organizations by sponsoring annual hospital-medical conferences, but has not heretofore been charged with the function of hearing and adjudicating disputes and/or complaints arising between physicians and hospitals regarding the practice of medicine in hospitals,

Be it hereby resolved: That the 1950 Sessions of the House of Delegates of the State Medical Society of Wisconsin in assembly at Milwaukee, October 1, 1950, endorse the action of the A. M. A. House of Delegates in adopting the report of the Committee on Hospitals and the Practice of Medicine (Hess Report) and hereby specifically charge the Committee on Hospital Relations of the State Medical Society of Wisconsin with the further duty of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen between a member of the medical profession and a hospital.

Be it further resolved: That if the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its judgment to that effect with its findings and recommendations shall be transmitted to the Council of the State Medical Society of Wisconsin, in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

It is hereby moved that Chapter VII, Section 15 of the Constitution and By-Laws of the State Medical Society of Wisconsin be amended by the addition of the following paragraph:

The Committee on Hospital Relations of the State Medical Society of Wisconsin is specifically charged with the responsibility of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine

in hospitals wherein a dispute has arisen between a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its findings to that effect shall be transmitted to the Council of the State Medical Society of Wisconsin with its findings and recommendations in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

REPORT OF WISCONSIN PHYSICIANS SERVICE

The following report by the Directing Board of Wisconsin Physicians Service was sent to delegates and alternate delegates in advance of the meeting:

Blue Shield of Wisconsin (Wisconsin Physicians Service), the agency of the State Medical Society, can again report to the House of Delegates steady growth in coverage and reserves for the past year. Growth has been constant and consistent since the plan's inception in 1946.

The Directing Board reports coverage on September 1, 1950 as 190,260, an increase of 48,701 in the last year. Reserves to June 30, 1950, have accumulated to $289,565.23 as reported on the quarterly audit.* The total figure represents an increase of $136,533.84 over that reported to the House of Delegates last year as of July 31, 1949.

Finances and Statistics

The balance sheet and statement of income and expenditures have been prepared from the auditor's statement and are attached to this report. Statistical information has also been summarized in additional reports. Numerous financial studies are constantly available to the Directing Board for comparisons. Such studies are prepared continually by the auditors from statistical information available from IBM material prepared by Blue Cross.

Contract Developments

In addition to the financial accomplishments, it was also possible to make the following three extensions of benefits on group contracts, effective October 1, 1949:

1. All surgical services are covered when rendered in the hospital. This is a rather extensive change as the first contract permitted benefits only for bed-patient surgery, plus outpatient emergency accidental surgery. Restrictions on hospital surgery were removed.
2. Emergency surgical services rendered anywhere by a doctor are now paid for when treatment is instituted within 24 hours of accidental injury. Such services were previously covered when performed in the hospital outpatient department. Now no restriction is placed on the doctor for emergency accidental surgery.
3. Diagnostic x-ray benefits were increased from $10 to $35 per contract year, for x-rays performed outside of a hospital by a doctor immediately preceding related surgery, or in treatment of related fracture or dislocation.

Recent Contract Developments

Only after careful study has the Board recommended changes in contracts. Economic trends and competitive problems are carefully watched. As a result of the latter, the Board introduced the following recommendations which were approved in total by the Council of the Society on June 3, 1950:

1. Introduction of the surgical-maternity contract at a lower monthly premium.
2. Extension of this basic contract by rider. The steel industry, bargaining with labor, has asked for a 70 day medical benefit. This coverage, or other variations, can be offered by rider on the basic contract.
3. Permission was granted by the Council to offer a cost-plus contract to large groups of carefully selected employees.
4. Authority was granted to the Board in its discretion, and not as a routine matter, to write group contracts for periods up to one year.

Future Needs

As a final recommendation, the Directing Board urged the Council to complete studies and determine policy at the earliest feasible date in the matter of higher benefit levels. Again the competitive factor is important as schedules are being offered by commercial companies at $200 and $300 per procedure. Certain other matters of basic importance are awaiting study by the actuary recently obtained by the State Medical Society. Further extension of the non-group contract may be anticipated after sufficient experience has been obtained. The Board will offer changes consistent with sound financial development.

Greater emphasis must be placed on a public and physician relations program. An immediate effort must be made to increase rural coverage and this problem will be given prompt study by the Board.

The cooperation and support of participating physicians have been of inestimable value. The plan must continue to have this support if it is to develop and prosper.

The Board considers it an obligation to constantly improve the facilities of the Blue Shield Plan and with the continued support of the medical profession, the utmost in promotion of voluntary plans can be attained.

E. M. Dessloch, M.D., *Chairman*
Ralph F. Weber, *Executive Director*

Finances and Statistics

Enrollment—September 1, 1950
Persons covered _____190,260
Groups covered _____ 2,339

* This amount has the following distribution: maternity reserves $97,020.00, reserves for disaster claims $45,532.00, unforeseen contingencies $116,582.24 and administration reserve $30,430.99.

Assets—June 30, 1950	$ 447,005.80
Plus: Unearned Premiums on Deposit	162,086.03
Total Assets as per report	$ 609,091.92
Total Liabilities as per report	$ 319,526.69
RESERVES—June 30, 1950	$ 289,565.23
Monthly Premium Income—June, 1950	$ 140,370.18
Total Premium Income—12/1/46 to 6/30/50	$2,846,323.60
Benefits paid to June 30, 1950	$2,092,462.65
Number of claims paid to June 30, 1950	46,687

WISCONSIN PHYSICIANS SERVICE

Madison, Wisconsin

ASSETS

Current Assets			
Cash in Bank—Administrative Fund		$ 43,656.07	
Cash in Bank—Service Benefit Fund		180,046.57	
Cash in Bank—Executive Account		200.00	
Petty Cash Funds		25.00	
Due from Agent on Premiums Earned		19,029.03	
Refunds Receivable		100.00	
U. S. Govt. Bonds—Service Benefit Fund	$199,900.00		
Less: Reserve for Reduction of Redemption Value—Series G Bonds	312.00	199,588.00	
Total Current Assets			$442,644.67
Deferred Assets			
Cash in Agency Account for Unearned Premiums		$100,557.52	
U. S. Govt. Bonds—Agency Account Par Value	$ 50,000.00		
Unamortized Premium on U. S. Govt. Bonds Agency Account	905.98	50,905.98	
Accrued Interest Income on U. S. Govt. Bonds—Agency Account		46.88	
Unearned Premiums Collected and Held by Agent		10,575.65	
Total Deferred Assets			162,086.03
Fixed Assets			
Office Furniture and Fixtures		$ 5,049.04	
Less: Accumulated Depreciation		856.81	
Total Fixed Assets			4,192.23
Accrued Income			
Accrued Interest Income on U. S. Govt. Bonds in Service Benefit Fund			54.17
Prepaid Expenses			
Unexpired Insurance			114.82
TOTAL ASSETS			$609,091.92

CERTIFIED BALANCE SHEET

June 30, 1950

(The accompanying notes of the complete audit are an integral part of this statement)

LIABILITIES AND RESERVES

Current Liabilities			
Accounts Payable		$ 1,396.71	
Accrued Expenses		334.18	
Physicians Claims Payable	$ 87,658.25		
Undischarged Claims	4,400.00		
Unreported Claims	35,640.00	127,698.25	
Total Current Liabilities			$129,429.14
Deferred Income			
Unrealized Income			161,913.52
Advances from State Medical Society of Wisconsin			
Funds Advanced		$ 20,000.00	
Development Expense Paid		8,184.03	
Total Advances			28,184.03
Service Benefit Reserves			
Maternity Benefits	$ 97,020.00		
Disaster Claims	45,532.00		
Unforeseen Contingencies	116,582.24		
Total		$259,134.24	
Administrative Reserve			
Balance April 1, 1950	$ 44,892.83		
Excess of Administrative Income over Expenditures—April 1–June 30, 1950	10,298.48		
	$ 55,191.31		
Less: Transfer to Reserve for Unforeseen Contingencies	25,000.00		
Balance—June 30, 1950		30,191.31	
Investment Reserve			
Interest Earned	$ 577.49		
Less: Premium Amortized $ 25.81			
Reduction of Redemption Value—Series G Bonds 312.00	337.81		
Balance—June 30, 1950		239.68	
Total Reserves			289,565.23
TOTAL LIABILITIES AND RESERVES			$609,091.92

WISCONSIN PHYSICIANS SERVICE

Madison, Wisconsin

COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES

December 1, 1946 to June 30, 1950

	1950						
	April	May	June	Total Second Quarter	First Quarter	Year to Date	12/1/46 to 6/30/50
INCOME							
Service Benefit Income—Group Contracts	$104,894.12	$107,038.26	$109,033.35	$320,965.73	$302,597.73	$623,563.46	$2,265,433.53
Administrative Income—Group Contracts	26,223.53	26,759.56	27,258.34	80,241.43	75,649.43	155,890.86	566,358.38
Service Benefit Income—Non-Group Contracts	1,997.76	2,481.12	2,800.80	7,279.68	3,286.56	10,566.24	11,163.36
Administrative Income—Non-Group Contracts	499.44	620.28	700.20	1,819.92	821.64	2,641.56	2,790.84
Interest Earned			577.49	577.49		577.49	577.49
TOTAL INCOME	$133,614.85	$136,899.22	$140,370.18	$410,884.25	$382,355.36	$793,239.61	$2,846,323.60
EXPENDITURES							
Physicians Claims—Group Contracts	$ 95,732.00	$107,038.50	$115,914.75	$318,685.25	$287,325.00	$606,010.25	$2,086,426.65
Physicians Claims—Non-Group Contracts	755.00	1,446.00	1,598.50	3,799.50	1,936.50	5,736.00	6,036.00
Development Expense			8,184.03	8,184.03		8,184.03	8,184.03
Expenses of Agent	16,086.79	15,496.84	15,763.66	47,347.29	41,712.36	89,059.65	322,936.12
Executive Salaries	791.67	791.67	791.67	2,375.01	2,375.01	4,750.02	24,425.02
Other Salaries	1,749.80	1,919.60	2,107.86	5,777.26	5,121.95	10,899.21	42,662.52
Honorarium to Medical Advisor	50.00	50.00	50.00	150.00	150.00	300.00	300.00
Legal Expense	330.00	517.62	386.55	1,234.17	819.00	2,053.17	9,722.79
Accounting Expense	263.12	1,000.61	280.50	1,544.23	1,499.60	3,043.83	9,131.96
Conference Expense	158.92	168.79	110.49	438.20	1,213.56	1,651.76	5,325.29
Travel Expense	104.16	131.36	118.96	354.48	309.76	664.24	7,555.47
Stationery and Supplies	506.98	370.07	531.84	1,408.89	346.73	1,755.62	8,949.11
Rent	275.00	275.00	275.00	825.00	817.05	1,642.05	7,767.05
All Other Expenditures	546.99	829.27	1,085.86	2,462.12	1,825.19	4,287.31	17,336.36
TOTAL EXPENDITURES	$117,350.43	$130,035.33	$147,199.67	$394,585.43	$345,451.71	$740,037.14	$2,556,758.37
EXCESS OF INCOME OVER EXPENDITURES	$ 16,264.42	$ 6,863.89	$ 6,829.49†	$ 16,298.82	$ 36,903.65	$ 53,202.47	$ 289,565.23

COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES (continued)

DISPOSITION OF INCOME DOLLAR							
Physicians Claims	$ .72	$ .79	$ .84	$ .78	$ .76	$ .77	$ .74
Expenses of Agent	.12	.11	.11	.11	.11	.11	.11
Other Administrative Expenditures	.04	.05	.10	.06	.04	.05	.05
Investment Expense**							
Addition to Service Benefit Reserves	.08	.01	.14*	.08*	.04	.06*	.09*
Addition to Administrative Reserve	.04	.04	.19*†	.03*†	.05	.01*	.01*
Addition to Investment Reserve**							
Total	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00

*These items reflect transfers from the Administrative Reserve to the Reserve for Unforeseen Contingencies upon authority of the Directing Board. The transfers each of $25,000.00, were authorized on May 28, 1949, November 16, 1949 and May 27, 1950.

**Amounts relating to investment expense and the Investment Reserve are too small to be reflected as percentages of total income above.

†These figures shown in red on original copy.

WISCONSIN PHYSICIANS SERVICE

Madison, Wisconsin

SUMMARY OF PER CENT UTILIZATION

December 1, 1946 to June 30, 1950

	1947	1948	1949	1950
January	%	%	86.10%	77.39%
February			62.66	74.11
March			77.35	75.50
First Quarter		72.21%	75.28%	75.65%
April	%	73.49%	77.39%	72.21%
May		72.31	67.53	79.24
June		98.15	90.86	84.06
Second Quarter	63.89%	82.04%	78.74%	78.60%
Year to Date	63.89%	77.66%	77.12%	77.18%
July	%	65.83%	74.26%	
August		76.85	75.42	
September		70.76	61.71	
Third Quarter	63.71%	71.21%	70.34%	
Year to Date	63.73%	75.06%	74.65%	
October	%	64.95%	69.15%	
November		71.81	74.90	
December		58.03	64.47	
Fourth Quarter	65.45%	64.73%	69.46%	
Year to Date	64.83%	71.66%	73.18%	

SUPPLEMENTARY REPORT OF THE COUNCIL ON SCIENTIFIC WORK

At the request of Dr. F. W. Madison, Milwaukee, member of the Council on Scientific Work, the secretary read the following supplementary report of that Council inasmuch as Doctor Madison was unable to be present to make the presentation himself:

"The Council on Scientific Work suggests a revision of the By-Laws because of the difficulty of committing out-of-state speakers to the preparation of a written paper, and some out-of-state speakers feel that they must refuse to accept invitations to appear here if they must prepare a written paper.

"Therefore, the Council on Scientific Work recommends an amendment to the By-Laws so that it is not obligatory upon scientific speakers to submit a written statement."

The report was referred to the Reference Committee on Reports of Standing Committees, on motion of Dr. J. K. Trumbo, Wausau, seconded by Dr. C. E. Zellmer, Antigo, and carried.

REFERENCE OF REPORTS AND RESOLUTIONS

Vice-Speaker MacCornack asked the secretary to announce referral of the various committee reports and resolutions to the reference committees. When the subject matter of resolutions or reports was related, those matters were referred to the same committee. Their reports will be found under the minutes of the second and third sessions of the House.

COMMITTEE ON NOMINATIONS SELECTED

Following a councilor district caucus, on motion of Dr. C. E. Zellmer, Antigo, seconded by Dr. J. W. Prentice, Ashland, carried, the following delegates were approved as members of the Nominating Committee:

District	*Delegate*
1	W. H. Costello, Beaver Dam
2	Carl O. Schaefer, Racine
3	W. T. Clark, Janesville
4	T. F. Farrell, Prairie du Chien
5	E. C. Cary, Reedsville
6	B. J. Hughes, Winnebago
7	H. A. Jegi, Galesville
8	A. A. Cantwell, Shawano
9	A. M. Christofferson, Waupaca
10	J. J. Sazama, Chippewa Falls
11	Charles W. Giesen, Superior
12	E. L. Bernhart, Milwaukee
13	J. D. Leahy, Park Falls

Adjournment

The first session of the House adjourned at 7:10 p.m.

SECOND SESSION

Monday, October 2, 1950

The second session of the House of Delegates convened at 6:30 p.m., Vice-Speaker MacCornack, presiding.

REPORT OF COMMITTEE ON CREDENTIALS

The Committee on Credentials verified the registration of 47 delegates, and five alternate delegates entitled to vote at this session of the House.

In addition, five alternate delegates and three councilors had registered their attendance.

On motion of Dr. C. O. Schaefer, Racine, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance

roll of delegates and alternate delegates totaling 52, was accepted as the official roll of this session of the House.

REPORTS OF STANDING COMMITTEES

The following reports of standing committees of the Society were considered by the Reference Committee on Reports of Standing Committees:

COMMITTEE ON CANCER

The work of this committee continues to be that of serving as the medical and scientific committee of the Wisconsin Division of the American Cancer Society.

During the past year the committee has met twice and has acted upon numerous matters concerning the medical activities of the Cancer Society. On the basis of past experience with the operation of cancer detection centers, the Committee on Cancer has suggested the substitution of examinations in physicians' offices for the operation of cancer detection centers. This has caused the committee to intensify its efforts in postgraduate education of physicians. Cancer clinics have been held in Baraboo, Wausau, Superior and Sheboygan, to augment the cancer symposia held at the University of Wisconsin with support of the Wisconsin Division. In addition, the Wisconsin Division of the American Cancer Society has assisted those planning the Annual Meeting and Councilor District Meetings by way of furnishing speakers on scientific subjects related to cancer.

Cancer research at McArdle Memorial Laboratory, Madison, has been generously supported out of funds supplied by the Wisconsin Division, in accordance with recommendations of the Committee on Cancer. These research studies are being continued and are periodically reviewed by your committee.

Recommendations

1. The shift in emphasis from cancer detection centers to examinations conducted in the offices of individual physicians places a special responsibility upon the profession. There is need to acquire all available knowledge on cancer research and experience which can be related to individual practice. Special skills are needed to acquire an alertness to conditions which might suggest cancer in patients seeking "Cancer examinations." The willingness of individuals to come to a physician for a check-up, even though well, should be encouraged and not treated lightly. Therefore, it is strongly recommended that each physician prepare himself to serve effectively as an individual cancer detection center; that the purposes and limitations of an examination be explained to a patient; that adequate but not excessive charges be made for an examination with emphasis upon cancer detection. Only by sympathetic approach on the part of the physician can this problem of early detection be met. The public needs sound and practical advice on this subject, and the individual physician is best prepared to give this advice.

2. While physicians are reluctant to speak to lay groups on the subject of cancer, such public contacts are sorely needed to make people aware of their individual responsibilities in preventive phases of this disease. Materials are available to assist with the preparation of such talks. Physicians are urged to assist the members of the Committee on Cancer by indicating their willingness to assist with this important phase of the educational program being carried out.

ADVISORY COMMITTEE ON CARE OF CRIPPLED CHILDREN

As the name of this committee implies, it is essentially advisory in its function. The medical program of the Bureau of Handicapped Children, Department of Public Instruction, is well established and has had medical supervision from its inception. Therefore, this committee normally meets once or twice a year to consult with Mr. Frank Powell, director of the Bureau of Handicapped Children, on the various medical programs carried on through his department. Until recently, H. Kent Tenney, M.D., has served as part-time medical advisor to Mr. Powell; more recently, Maxine Bennett, M.D., has assumed this position on a full-time basis, and she will become closely associated with the Advisory Committee in its future activities.

For several years the Bureau of Handicapped Children has been active in the operation of the Kiddie Camp, Madison, for the care of children afflicted with rheumatic fever. Working in close cooperation with Chester Kurtz, M.D., an evaluation of therapy has been conducted. On the basis of evaluations made, some important results have been achieved in relation to optimum benefits derived from continued bed rest. Also, in order to achieve a broader base of service, special courses for visiting nurses have been conducted, to prepare them for the care of rheumatic fever patients in the homes they serve. This plan of extension medical and nursing service suggests a revised approach to this medical problem and will serve to shape the development of future programs in other parts of the state. A more complete report on this important medical and public health problem will be made at a later date.

The continuation of the orthopedic clinics has worked to the satisfaction of physicians faced with special problems in this field. Procedures have been established so all medical findings at the clinics are transmitted back to the family physician, who carries out the recommendations of the orthopedic specialist serving the clinic. County societies continue to exercise a choice of consultants, and the continued acceptance of this program is testimony of its fundamental soundness.

The lack of facilities for those afflicted with cerebral palsy has concerned the Advisory Committee for some time. The committee is pleased to report that steps have been taken in Milwaukee through the organization of lay interest with proper medical direction. While the diagnostic clinic in that urban-

ized center is still in its infancy, its results even at this early date are significant, and indicate a real need for similar services in other parts of the state. Indications are that the Wisconsin Association for the Disabled may provide a similar diagnostic and treatment center in Madison.

The most gratifying feature of this individual committee report is the continued understanding which exists between the director of the Bureau of Handicapped Children and the physicians comprising the advisory committee. The philosophy which actuates the programs carried on under the direction of Mr. Powell indicates that a governmental agency, *with proper direction,* can work in harmony with the medical profession. The philosophy of Mr. Powell, that the state agency exists only to provide help as a demonstration to local communities and to stimulate the development of local initiative and responsibility, has been the central core of the medical programs carried out by the Bureau of Handicapped Children. Likewise, these programs encourage individual responsibility of payment of services, within the financial ability of the recipient of service; a most unusual and encouraging philosophy for a governmental agency in this age of "free for all, for everything."

Recommendations

The committee recommends:

(1) That county medical societies encourage their public health nurses and visiting nurses to avail themselves of the opportunity of securing training at the Kiddie Camp for the extension home care nursing of rheumatic fever patients.

(2) That continued support be given the orthopedic clinics by individual county societies, so that services to physicians can be rendered by specialists, who can assist with diagnosis and recommended therapy without disturbing the physician-patient relationship.

(3) That physicians assist whenever possible in giving proper medical direction to lay groups concerned with specialized problems in the care of patients suffering from cerebral palsy or epilepsy, so that treatment facilities are not set up without proper medical direction and adequate specialized consultation service directly related to the ailment.

COMMITTEE ON COORDINATION OF MEDICAL SERVICES

This committee meets only about once each year, as there seems little general concern among the medical profession as to prevailing practices at the State of Wisconsin General Hospital relating to the admission of patients. However, with the expansion of facilities contemplated in the near future it seemed appropriate that this committee meet with administrative heads of Wisconsin General Hospital and the Medical School to review current practices and policies.

It may be recalled by many delegates that when the State of Wisconsin General Hospital was originally built there was a general agreement, approved by the Regents of the University of Wisconsin, that the ratio of private patients to public and special rate patients would be roughly 10 per cent of the total bed capacity. During the ensuing years there was some question as to the method of admitting private patients, and in 1935 a regulation was established by which admissions could only be accepted upon direct referral of a practicing physician.

In the main, the committee is satisfied these regulations have been adhered to as intended by those who drafted the restrictive regulation. From reports the committee feels that at times county authorities have been somewhat lax in refusing to certify as to the financial stringency of patients, whereby they are admitted as public or special rate patients, instead of being properly classified as private patients. But this is not of primary concern to your committee, which has been charged with the responsibility of ironing out any misunderstanding which exists between private practitioners and the administration of the hospital responsible for the acceptance of patients.

In September 1949, by action of the Regents of the University of Wisconsin, the original regulation concerning the ratio of private patients to total beds was changed so that at the present time the administration of Wisconsin General Hospital is authorized to accept up to 20 per cent of total bed capacity as private patients. On the present basis of 750 beds this would mean a maximum allowance of 150 private patients; on the basis of the enlarged plant, with 900 beds, this would mean a maximum of 180 private patients occupying beds at one time.

As will be noted in the statistics given below, the average number of private patients per day has been 115, which is below the maximum limit of 150 (20 per cent of 750 beds).

The committee is aware of the fact that the lesser number of hospital days for private patients, (23.9 as against 61.5 for public patients) permits the extension of services to a greater number of private patients than a flat 20 per cent of bed capacity, but the committee is also aware of the fact that the assignment of all bulbar polio patients to Wisconsin General Hospital is a factor, inasmuch as these assigned cases are all classified as private patients.

In reviewing the entire question of admissions of private patients to Wisconsin General Hospital it seems appropriate to the committee to point out to the House of Delegates that the institution is essentially a "teaching hospital," and the use of private patients for teaching purposes permits the faculty to utilize a wide cross section of cases, rather than a highly selective type of unusual cases which are referred through outside sources. It is as important for medical students to view the management of acute appendicitis in a private patient as it is to witness the management of some obscure disease referred because of inadequate facilities for treatment in some far distant portion of the state. While the ratio of private patients to public and special rate patients should not exceed the new level of

20 per cent of total bed capacity without review and consultation of the State Medical Society, the Committee on Coordination of Medical Services is convinced that those responsible for the management of the State of Wisconsin General Hospital and the Medical School are sincere in seeing that the prevailing regulations are adhered to without deviation. Your committee feels, however, that the medical profession itself has a direct responsibility in seeing that patients who are referred are properly classified, and not certified as public or special rate patients when financially able to cover the hospital and professional charges themselves. Likewise, it appears desirable in those localities most directly affected by the admission of private patients that the county societies involved establish codes of ethics which will prevent or discourage the referral of patients unless there is justifiable reason for doing so. The use of local facilities should be encouraged, unless there are professional reasons for the referral of patients to the State of Wisconsin General Hospital.

Listed below is a statistical summary of admissions during the past year, as against the previous year:

Year	*Total*	*Public* %	*Special Rate* %	*Private* %
ADMISSIONS				
1948–49	11,789	51.8	16.1	32.1
1949–50	12,480	48.6	20.8	30.6
AVERAGE NUMBER PER DAY				
1948–49	467	64.5	15.4	20.1 (94)
1949–50	479	61.6	14.4	24.0 (115)
HOSPITAL DAYS				
1948–49	170,606	64.4	14.3	20.3
1949–50	174,937	61.5	14.6	23.9

Your committee is prepared to investigate any complaints of physicians who feel that the prevailing agreement in respect to the admission of private patients is being violated. On the basis of prevailing practices the Committee on Coordination of Medical Services feels that the administration of the hospital and the medical school is controlling the extension of services to private patients in keeping with existing regulations, and that the State of Wisconsin General Hospital is being maintained as an effective teaching hospital, and a source of help to private practitioners throughout the state.

Your committee welcomes any opportunity of service it can render.

COMMITTEE ON GOITER

The work of this committee has become static for the moment. For the past several years the committee has urged the continued use of iodized tablets in the public and parochial schools of the state, to supplement any necessary amount of iodine which might not be absorbed through the use of iodized salt. The committee recognizes that universal use of iodized salt would give the consumers sufficient protection against thyroid disease, but, as an added precaution, the committee has recommended the continued use of iodized tablets.

To help promote interest in this preventive program, the committee, in cooperation with the Bureau of Maternal and Child Care of the State Board of Health, has widely distributed among schools and PTA groups a leaflet entitled "Help Your Child Avoid Goiter." The wide acceptance of the recommendations given in this leaflet has resulted in more than 90 per cent of the elementary children in rural areas being given protection through the use of iodine tablets. Also, many city schools (notably Madison), heretofore not actively identified with this preventive program, have accepted the recommendations of the Commitee on Goiter, and have begun the distribution of iodized tablets.

To date most of the preventive program has been carried on in the elementary age group, and it is recommended that individual physicians and county societies advocate continuation of the iodine tablet program through the secondary school level.

While there is no need to have this committee engage in any special activities, it is suggested that the committee be retained, so that periodic surveys can be made to determine the effectiveness of the present program, and properly evaluate the necessity of continuing the advocacy of using iodized tablets to supplement the use of iodized salt.

COMMITTEE ON GRIEVANCES

This committee has been unusually active this past year, and the conclusions of its meetings should be brought to the attention of the House of Delegates. The Committee on Grievances has held six meetings since the last session of the House. Its increased activity has been prompted by a growing recognition on the part of the medical profession, in Wisconsin and elsewhere, that the consuming public as well as the profession itself has a right to be heard on any legitimate complaint concerning medical practice.

At national meetings during the past several years this problem has been given special attention. Many states have reported unusual procedures followed to provide an avenue for professional discipline and a means whereby the consumers of medical care might place their grievances before a responsible medical body sufficiently detached from the local situation so as to render unbiased judgment.

The first year of activity of the committee reveals several matters which should interest members of the House of Delegates. Without general publicity, a total of 55 complaints have been carefully studied and reviewed since last October of which 22 have been closed at the time this report was prepared. A confidential method of keeping records has been evolved, so that with the use of code the names of the complainants and those charged with improper medical practice are known only to the members of the committee. Many of the cases brought to the attention of the committee have required long and careful investigation; others have been settled with little difficulty; others have been held in open files to await further developments.

During the past year most of the complaints have come directly from consumers of medical care who, in some manner or another, learned of the existence of the committee. In many cases the complaint was satisfied through investigation, but on several occasions the complainant was personally invited to meet with the Committee on Grievances and discuss his or her problem. In most instances the committee found that the complaint was based upon misunderstanding or the fact that the physician in contact with the patient did no give an adequate explanation of the medical problem involved. The committee is impressed that some physicians seemingly fail to give the patient all facts in the case, and in many instances the result is misunderstanding or suspicion that the physician was negligent or that there was a basis for malpractice when no such basis existed. In many cases the reputation of the physician involved was jeopardized because of repeated complaints, which might well have been satisfied by proper explanations on the part of the physician at the time of treatment.

The medical profession is constantly fraught with the possibility of complaint and dissatisfaction. While most of this stems from misunderstanding or lack of adequate information on the part of the consuming public, the profession must meet this situation with courage and high resolve. To merely apply a "whitewash brush" to all complaints will serve only to reenforce the now existing feeling on the part of a large segment of the public that medicine quietly ignores its mistakes. While the committee recognizes that any human may err in judgment and make mistakes which are harmful to the patient, there is need to exercise strong control over the occasional physician who forgets the ethics of his profession and by his conduct, and practice brings dishonor to his colleagues as well as himself.

In filing this brief report, the Committee on Grievances asks for continued support on the part of the entire profession. As complaints reach the county societies which cannot be adjudicated on a local level or which seem of too serious a nature to be settled locally, your Committee on Grievances stands ready to do what it can to adequately represent the profession and also to represent the citizens of Wisconsin, who, as consumers of medical care, have a right to feel that the physicians associated with the State Medical Society of Wisconsin are conducting themselves properly and rendering service to the very best of their ability.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

As other committees of the State Society have been formed, the scope of activity of this committee has been narrowed to methods employed by the State Medical Society to disseminate medical information to the lay public. The committee has reviewed the progress of the radio program and the work of the director of public information as it relates to exhibits, public talks by physicians, and so forth.

The Committee on Health and Public Instruction reports continued growth of the radio program, with two stations added this past year, and the loss of one outlet in Superior. The increased public response by way of "fan mail" reflects growing interest in *The March of Medicine*. Under the direction of Doctor Parkin these programs have developed more variety of presentation than heretofore, and it is anticipated that with the use of a tape recorder more interviews can be conducted outside of the broadcasting studio.

An increasing number of lay exhibits have been presented this year under the active direction of Mr. Earl Thayer, director of public information.

COMMITTEE ON HEARING DEFECTS

During the past three years this committee has served as an advisory committee to both the State Board of Health and the Bureau of Handicapped Children in the development of hearing programs which have gone far beyond the scope of screening surveys, so often characteristic of public health projects.

The Committee on Hearing Defects has assisted both state departments with medical aspects of their programs and has correlated practices so that the same type of program is being carried on in each state department. The committee is pleased to report significant progress during the past year, not only in a widening scope of activity but also a more critical evaluation of medical services rendered through the otologic clinics.

A review of the activities this past year indicates that an increasing number of physicians are cooperating with these programs, and, through the policies laid down by this committee, the operation of the otologic clinics retains rather than destroys the patient-family physician relationship, which is so often endangered by programs of this character.

Continuing the program reported in the last report of this committee, the State Board of Health has concentrated in the Eighth Public Health District and Marathon County, while the Bureau of Handicapped Children has covered most of the counties in other parts of the state. In total, 41 counties are now being served on an all-school basis through the two programs, and 12 additional counties have indicated a desire to participate in the program during the ensuing year. Lack of skilled personnel has held back further expansion, as it is felt by the committee and those most directly responsible for the administration of the programs that expansion should come only as personnel can guarantee the maintenance of standards set and followed to date.

It is interesting to note that during this past year 147,122 school children were tested for hearing loss; 7,997 given careful rechecks through audiometer readings, and 2,318 examined by otologists at special otologic clinics.

The most significant part of the Wisconsin program is not the extensive testing done or the number of children given audiometric studies, but rather

the successful operation of the otologic clinics, and the care taken by the specialists rendering this service to refer the patient back to the family physician for continued study. The basic principles of the orthopedic clinics have been followed in the operation of the otologic clinics, and the success of these special examinations accounts to a large degree for the outstanding record made in follow up of patients needing special attention. The two programs report 66 one day clinics, with an average patient load of 35 per clinic. This means that during the year nearly 2,000 children with hearing defects have been examined by specialists and have been started on a sound program of rehabilitation.

In some localities the profession has questioned the use of lay persons, such as teachers or parents, to conduct the initial screening of students. Experience shows that lay persons charged with the responsibility of initial screening are extremely conscientious and, if anything, err on the side of caution in evaluating the need for further study by medical personnel. The committee feels that this is a very important part of the program and serves to save time and effort of physicians and nurses who participate in the program.

While Wisconsin has made a significant record in the development of its hearing program among the children attending our public and parochial schools, the committee is not content with the present status of the project. Both state departments have been asked to conduct critical evaluation studies of those who have been under medical care to make sure that the person served feels that everything possible has been done to be of assistance, and also to see what real progress in rehabilitation has been made. To survey and not follow up is useless, and Wisconsin has recognized this in both state plans; but it is of equal importance to evaluate the services rendered in follow-up programs, and the committee anticipates an interesting and important report on this to be made to the 1951 House of Delegates.

While dramatic progress has been made in the widening scope of the hearing conservation programs conducted in the state, there are evidences in certain areas that some physicians are inclined to view the work being done by the two state departments as a form of socialized medicine. So long as the Committee on Hearing Defects has the close connection it exercises in shaping the policies of both programs, there is little danger that participation in the work being done on a local level will lead to federalized medicine. Quite the contrary is true, for both programs are estabished and maintained purely on a demonstration basis, and, from the beginning, efforts are made to create a sense of local responsibility, so that the program will be carried on without state and federal support after several years of operation.

The committee is pleased with the growing acceptance of the program, and it urges county societies to give the project their wholehearted support.

COMMITTEE ON INDUSTRIAL HEALTH

For the past several years the Committee on Industrial Health has sponsored special meetings of industrial nurses, physicians, and plant officials most directly concerned with industrial health practices and procedures. No other state has carried on such a comprehensive program of industrial health education, and the clinics have been well received by the profession and allied groups.

This past year three clinics were held: in Wisconsin Rapids, Kohler, and Milwaukee. A total of 365 persons attended these meetings: 189 physicians, 105 industrial nurses, and 71 representatives of industry. Following the pattern of similar meetings held in former years the clinics consisted of a plant tour, a scientific program related to industrial health topics, and a dinner meeting at which Drs. Chester Kurtz, Madison, and Le Roy Sloan, Chicago, spoke on heart disease as related to industrial practice.

While the clinics held during the past several years have been uniformly successful, there is some question as to whether these special industrial meetings should be held continuously. Most sections of the state have been covered by meetings of this type, and there seems to be little appeal for continuation of this type of medical meeting on a repeated basis. Efforts will be made to see if certain communities not yet utilized for clinics wish to have this type of meeting in 1951, and plans will be based upon responses.

The publication of the workmen's compensation panels for 1950–51 has been an important and an arduous task. Initially, more than 45,000 panels were distributed to employers covered by workmen's compensation. Following the general distribution several thousand additional copies were distributed upon request. The wide acceptance of the open panel program, and the participation of more than 75 per cent of the members in the program indicate that free choice of physicians in the treatment of industrial injuries is an accepted and acceptable feature of the industrial health program in Wisconsin.

The Committee on Industrial Health had in its previous report suggested the advisability of revising literature on the pre-employment examination program, initially established in 1939. Efforts have been made to have a special medical committee appointed by the Industrial Commission to review this publication and incorporate needed revisions.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

This committee has met twice during the past year, and it is anticipated that its studies will necessitate further conferences to correlate its findings in respect to physician population, the present and future output of graduates from our two medical schools, and related subjects.

During this past year the committee has given consideration to trends in medical education, especially as related to the experience of our two medical schools. It has sought to analyze the statistics in

relation to enrollment, and particularly the location of graduates from both Marquette University and the University of Wisconsin to see if there is any justification in the popular complaint that there is a marked lack of available medical care in Wisconsin. Its studies have concerned themselves with varying road conditions, the location of hospitals, and the broadened base of medical service due to changes in transportation, modern methods of therapy, and greater utilization of hospitals for medical experiences formerly treated in the home.

The Committee on Medical Education and Hospitals is well aware of the fact that there is little public understanding of the complexity of modern medical education. One important project which the committee feels essential is that of better interpretation of this problem on the local level.

The committee proposes to continue its studies during the ensuing year and periodically review the enrollment practices of the two medical schools, to see what steps can be taken to completely utilize the teaching facilities without a resulting sacrifice in standards of training given the young men and women preparing themselves for the practice of medicine.

COMMITTEE ON RURAL HEALTH AND ACCIDENT PREVENTION

In an effort to achieve the best in health for the rural people of Wisconsin, the Committee on Rural Health and Accident Prevention has pursued a program to bring facts and views on present day requirements for health and safety to the attention of those who live in the country.

With a view to helping young people assume greater personal responsibility for their own health and health conditions in their communities, the committee has continued to expand the 4–H Club health education program in cooperation with the directors of 4–H Club work and Home Economics Extension at the University of Wisconsin. 4–H club members are encouraged to see their physicians for yearly health examinations, individually and at their own initiative, rather than on a mass basis, since this is the method they will use when they become older.

Through this committee the State Medical Society sponsored the attendance of eight 4–H Club boys and girls at a two-day health camp at Green Lake, Wisconsin; one all-expense trip to the National 4–H Congress in Chicago, for the 4–H Club member who has done the most outstanding work in the family and community health; and awarded 29 "Certificates of Achievement" to 4–H Clubs completing outstanding health projects during 1949. Twenty-five county medical societies provided 30 scholarships to 4–H Club members going to summer health camp.

Greater emphasis on health at the 1950 Farm and Home Week program, January 30 to February 1, was achieved through cooperation with Agricultural Extension of the University of Wisconsin. More than 12,000 farm people attended the three-day session at which the State Medical Society sponsored the appearance of Dr. Franklin D. Murphy, dean of the University of Kansas Medical School, on a general session program to discuss the responsibilites of rural communities for getting and holding physicians in rural areas. Four outstanding exhibits—Diseases Transmitted from Animals to Man, Tularemia, Mechanical Nostrums, and Safeguarding Your Health —were presented by the committee and visited by thousands of persons.

Early in 1950, the committee called together representatives of nearly 50 farm, health, governmental and civic organizations interested in problems of rural health. As a result of this conference, plans are under way to hold a 1950 Wisconsin Rural Health Conference at Green Lake, Wisconsin, September 22–23, under the sponsorship of the State Medical Society with the 50 interested groups as cosponsors. Your committee chairman heads the Executive Committee of the Conference, and, with the cooperation that has been given to date, it is contemplated that 300 to 400 "grass roots" farm people will participate in discussions of the supply of physicians, hospital facilities, prepayment health plans, and means of organizing health councils and city-county health departments.

Recommendations

1. Continuation and improvement of the 4–H Club Health Education program.
2. Establishment of an effective farm safety campaign, including an accident prevention exhibit at the 1951 Farm and Home Week.
3. Greater utilization of scientific programs on brucellosis in county medical societies.
4. Continuation of the Wisconsin Rural Health Conference in 1951.

COMMITTEE ON MATERNAL AND CHILD WELFARE

This committee will review the results of hospital questionnaires which were sent out to obtain information that might clarify present factors in Wisconsin. It is the hope that such study may lead to improved maternity, infant, and pediatric services and further reduction of stillbirths and infant deaths, especially among the group of babies born prematurely. This second questionnaire, as a follow-up of one sent in 1946, was to determine progress and to clarify present problems of physicians and institutions responsible for care. Prevailing practices were explored, especially as to demand from patients created by present emphasis on rooming-in, "childbirth without fear," and self-demand schedules which have been so widely expounded in lay publications. Facilities for premature care and the hospital experience with prematures under 3 pounds, 3 to 4 pounds, and over 4 pounds were among the details included as were stillborn infants.

In the past decade Wisconsin hospitals, in spite of the problem of obtaining adequately trained staffs, have extended their obstetric services by more than 170 per cent. It is apparent that greater safety has been provided for both mothers and babies, as shown

by the mortality data of 1949, which reached new lows with 47 maternal deaths (0.6 per 1,000 live-births); 2,193 infant deaths (26.5 per 1,000 live-births); and 1,274 stillbirths (15.4 per 1,000 live-births). In spite of this record the committee recognizes there are still unnecessary deaths occurring. It hopes through its studies to aid physicians and hospitals throughout Wisconsin in constantly improving their facilities and services. It is in a position to review new trends and to encourage taking full advantage of all facilities that will not only save lives but aid parents to provide better physical and emotional care for their children. Self satisfaction and complacence are not in order. Constant vigilance is the price of progress. Each doctor and each hospital must continue to make searching inquiry of maternal and infant deaths and stillbirths as well as morbidity. There is also much to learn about premature deliveries and handling babies that arrive prior to term.

The opinion of the committee is that postgraduate education in obstetrics and pediatrics and hospital staff education remain a great need. Although the response of physicians in some areas seems at times discouraging, the enthusiastic response of others and the actual results as reflected in lower mortality rates and fewer stillbirths would indicate that this approach holds continuing possibilities. One senior resident from Children's Hospital, available in May, was assigned to Grant, Iowa, Crawford, and Richland counties for discussions and demonstration of pediatric technics. The Bureau of Maternal and Child Health is continuing to extend education services to doctors and to hospitals. Hospitals are also benefiting from loan of incubators and educational materials. Southwestern Wisconsin, with many small hospitals and many scattered physicians, re-emphasized the need for very careful planning and wide publicity to special programs. A postgraduate service in obstetrics and pediatrics similar to those successfully operating prior to the war is now being organized for northwestern Wisconsin, with a faculty from the State University of Iowa College of Medicine. An evaluation of past programs by those who have participated re-emphasizes their value not only to the attending physicians but to teaching schools in keeping close touch with problems away from medical centers. Often, planned programs reach too small a number of the physicians. Our Wisconsin programs need the full support of every physician and of every hospital. By working with and through the facilities of the State Medical Society, the State Board of Health, and local communities, progress will continue.

COMMITTEE ON MENTAL HYGIENE, INSTITUTIONAL CARE, PUBLIC WELFARE AND STATE DEPARTMENTS

This committee has met three times during the current year. Continued study has been directed to improved care given in county institutions, as well as the programs at Mendota and Winnebago.

The committee has tried to impress the Legislative Council with the urgency of enacting enabling legislation for the erection of county infirmaries. The committee is hopeful that the 1951 legislature will meet this problem with courage and statesmanship. Likewise, the committee sees need for more regulation of nursing and boarding homes, and suggests that the State Society support legislation in this field.

While progress has been made in the care of the mentally ill on the state level through improved facilities at both Mendota and Winnebago, the committee is aware that care on the county level is, with some notable exceptions, far below minimal standards, in respect to both medical care and therapy. It is anticipated that with the employment of Dr. Leslie Osborn more help can be expected through the Department of Public Welfare, so that county care programs can be materially improved.

The Committee on Mental Hygiene has directed its major attention to an evaluation of facilities for the care of the mentally disturbed patient, through both hospitals and institutions. It is aware that the preventive program is of equal importance, and more support by the medical profession is needed for the expansion of preventive programs on both the juvenile and adult level.

Your committee recommends that for the coming year:

1. The State Medical Society direct the Committee on Public Policy to again sponsor legislation to meet the need of the aged by reintroducing a bill similar to that presented to the 1949 legislature, which would permit county infirmaries to be built out of county funds and with state support for care of state patients.

2. The Department of Public Welfare be encouraged to study the advisability of introducing legislation which will provide for adequate regulation and inspection of nursing and boarding homes so as to provide a better type of care than is now the case.

3. More efforts be made by physicians, as members of local hospital staffs, to have a minimum of facilities available for the care of the mentally disturbed, before surgery or before being transported to Mendota or Winnebago for treatment. Further, that hospitals of sufficient size to maintain departmental organization be encouraged to establish a psychiatric service to concern itself with prevention as well as treatment in acute cases of neurosis.

4. Local county medical societies give support to the establishment of mental health centers, properly staffed and under the immediate direction of responsible medical authorities.

COMMITTEE ON PUBLIC POLICY

The Committee on Public Policy concerns itself primarily with legislation affecting the affairs of the State Medical Society. This being a non-legislative year, the Committee on Public Policy has not met since the close of the 1949 session.

It is anticipated that during the next two months this committee will renew activity, with special attention directed to the Medical Practice Act and suggested revisions which have direct bearing upon the practice of medicine in Wisconsin.

There are many legislative problems confronting the Medical Society. Your Committee on Public Policy urges your individual and collective interest in the various bills which will be presented through the State Society, and the anticipated legislation which would adversely affect our profession and its service to the citizens of the state.

In reviewing other committee reports, it will be seen that many matters will be presented to our committee for review and evaluation. The problem of the aged is still with us and suggests proposed legislative action; the broadened scope of licensing osteopaths suggests certain interpretations of statutes, to make sure that the intent of the 1949 legislature is carried out in the interests of patients most directly affected by this legislation. These and many related problems will be before the 1951 legislature, and your Committe on Public Policy requests more active support than the acceptance of this general report. Your committee can function most effectively if individual physicians closely associated with the legislators will inform themselves on bills most vital to medicine, and carry out the suggestions of the Committee on Public Policy in interpreting the views of organized medicine in a manner which is forceful and reflective of understanding of content of the major bills.

COMMITTEE ON TUBERCULOSIS AND CHEST DISEASES

Only one meeting of this committee has been held during the current year, as the main function of the committee is to review existing programs and to evaluate progress made in the control of tuberculosis in Wisconsin.

At the suggestion of the Committee on Tuberculosis and Chest Diseases, the State Board of Health has reactivated the consultation committee, whereby tuberculosis sanitaria are able to secure an evaluation of services and consultation as to medical and administrative procedures. To date, the major function of the consultation committees rendering this service has been medical in character, and efforts are being made to secure the cooperation of the Wisconsin Hospital Association to supply skilled administrative talent so that the consultation service can be more complete than it has in the past. This service to the various tuberculosis institutions in the state has resulted in the development of more constructive programs on the local level and a better correlation with medical practices on a state-wide basis.

The committee has reviewed the effect of the 1947 law which permitted a school board to expend public funds for the examinations of school personnel. This law was passed at the suggestion of the Committee on Tuberculosis, with the view of detecting tuberculosis among teachers and other school employees before contacts with children led to a spread of the disease. A recent survey, as reported to the Committee on Tuberculosis and Chest Diseases, indicates that few communities have taken advantage of the 1947 law, and the committee recommends that each county society give special attention to this problem during the ensuing year, by impressing upon school authorities, parent groups, and others most directly concerned, the advisability of having all school employees give proof of freedom from tuberculosis as a condition of employment and of having periodic re-examination of all persons under contract of the local school boards. To implement this program it is further suggested that the county medical societies establish a fee schedule which will be uniform throughout the county for such services and that, wherever possible, the school personnel be given advantage of screening programs conducted by the State Board of Health and the Wisconsin Anti-Tuberculosis Association.

During the past year the Committee on Tuberculosis and Chest Diseases has conducted a study of prevailing practices in other states as to special laws or local ordinances in reference to examinations of special groups, such as bartenders, food handlers, etc., who through their vocational activities might be in a peculiarly favorable position to spread tuberculosis. To date, this study has not revealed any practical avenue through which the objective of control can be achieved, but the committee will continue its studies and if any recommendations are to be made in this area such recommendations will be submitted to the House in its next report.

Some progress has been made since the last report of this committee on the establishment of routine miniature film examination of all hospital admissions, but there are still many communities in which this program might be started with benefit. Evidence submitted to date indicates that such routine examinations are highly desirable from the standpoint of good public health, and, whenever the hospital load is heavy enough to make such a program practical from an administrative standpoint, its inauguration should be encouraged. While the pattern of such programs has been established in pilot studies carried on in Wisconsin and elsewhere, further expansion will come about by aggressive action on the part of hospital medical staffs and county medical societies. It is strongly urged that county societies carry on local investigations as to which hospitals could carry on such a program with value to the patients served, and then make strenuous efforts to see that such examinations are recognized in the county as routine hospital procedures. Without leadership from the medical profession and an understanding of the problem by the lay public served, there can be little progress made in this important field of tuberculosis control.

The problem of repeated commitment of patients who do not voluntarily stay in sanitaria until fully cured has concerned the Committee on Tuberculosis and Chest Diseases. The cost to society for repeated treatment and the ultimate seriousness of

the disease which might have been fully cured in initial stages suggest that more attention be given this problem by social workers, judges, and others who are in a position to influence the person either committed for treatment or accepting treatment on a voluntary basis.

While the committee cannot report an elimination of tuberculosis to a point where there is no further need for this committee within the structure of the State Medical Society, it can report definite progress both in the control of the disease and in a better correlation of medical practices in institutions devoted to the care of the tuberculous patient. The greatest need is still the early detection of the disease, and, while the mass survey programs have an important part to play in the control of tuberculosis, it still remains for the individual practitioner to detect most cases and to use his influence to see that the patients are properly treated and encouraged to remain in sanitaria until entirely free from the disease. The decline of tuberculosis has resulted in a certain amount of professional apathy to the problem. It is hoped that individual physicians and county societies will take steps in eradicating this problem to an even greater degree through continued study of newer forms of therapy and continued alertness to early signs of the disease in their patients.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

The Council on Medical Service and Public Relations has continued its program of improving the relationship that exists at the point where doctor and patient meet. Part of this program is aimed at making physicians more public relations conscious and encouraging policies and activities that will result in better medical service to the people of Wisconsin. Another part is that of informing and making friends of the public.

Organized methods of handling night and emergency calls for medical attention are being established in counties and cities throughout the state under the stimulus of this Council. County societies have been supplied with information outlining successful systems for handling emergency cases, and in the year since the last report of this council, several cities have set up emergency call plans and others have plans under consideration. Assistance given to newspapers publicizing these plans has emphasized the public's obligation for their successful operation.

The Physicians' Location Service continues to be an important factor in bringing physicians to communities needing them and helping physicians obtain desirable locations. During the year, 39 requests have come from communities seeking physicians. A total of 63 requests were received from physicians seeking locations, locum tenens, associations, etc. During the same period, nine communities requesting physicians were removed from the "available" lists because a physician had settled there. It is encouraging to note that the Physicians' Location Service is more and more becoming the center through which requests for physicians or practices are being channelled.

Press and radio activities have improved the Medical Society's standing as an authoritative source of information on scientific and economic medical subjects. Since the last report of the council, 92 separate news releases have been issued in the name of the Society. Releases to both daily and weekly papers have received wide publication and both press and radio are to be commended for their fine support of public education projects of the Society. Radio stations in several major cities have been extremely cooperative in publicizing and broadcasting speeches on socialized medicine.

Starting in July, 1950, an article on some phase of the State Medical Society's committee activities appears in each issue of the State Board of Health's bimonthly publication, "Health." This has a circulation of over 14,000 among public health and lay people.

Exhibits emphasizing the role of the medical profession in safeguarding the health of the public have been shown to audiences totaling about 25,000 persons. More than 14,000 pamphlets were distributed at these showings.

As part of the effort of the National Education Campaign to defeat socialized medicine and expand voluntary prepaid health care plans, the council has established a Speakers Bureau, composed of 115 physicians and 30 laymen, through which 78 speaking engagements were filled over an eight-month period. A monthly bulletin entitled "Speakers' Notes," accompanied by the latest information material, is sent to all members of the Speakers Bureau. Informational packets on health insurance were supplied to 221 individuals, organizations and schools.

Recommendations

1. Development of adequate portable exhibits on prepaid health care plans approved by the Society and the work and services of the State Medical Society to be used at fairs, conventions, and organizational meetings.

2. Expansion of night and emergency call systems so that where no county or city plan is in operation arrangements are provided through the staffs of all approved hospitals.

3. Approval of the establishment of a Wisconsin Physician's Aid Association to provide aid to needy doctors of medicine in emergency need, and to needy widows and minor children of deceased doctors of medicine.

COMMITTEE ON VISUAL DEFECTS

For the past several years this standing committee has been inactive, but it suggests continuation so that, as matters restricted to the field of ophthalmology arise, this committee will be prepared to serve the Society and make its report and recomendations to the House of Delegates.

COUNCIL ON SCIENTIFIC WORK

The work of the Council on Scientific Work concerns itself mainly with the development of the Annual Meeting program, circuit teaching clinics, and the development of scientific programs for councilor district meetings. This past year the Council has undertaken to develop a more direct type of teaching program for the Annual Meeting, and the reaction of members to this feature of the program will determine to what extent it will be continued in the future.

For nearly 10 years the State Medical Society has featured circuit teaching programs during the spring months. These meetings have been uniformly well received, but it has been felt by members of the Council on Scientific Work that a more comprehensive type of teaching program should be developed. Therefore, beginning in 1951, an attempt will be made to establish certain teaching centers in which medical continuation courses will be developed by the faculties of the University of Wisconsin Medical School and Marquette University School of Medicine. The major cost of the instructional courses will be underwritten by funds of the Wisconsin State Board of Health.

The Council on Scientific Work is anxious to provide the best possible type of in-service training programs for members of the State Medical Society of Wisconsin. It is hoped that the replacement of the "Spring Clinics" with the newer type of teaching program will serve more members and will provide a more direct form of instruction. The success of this new form of postgraduate teaching will be reported to the House of Delegates one year hence.

REPORTS OF REFERENCE COMMITTEES

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

The Reference Committee on Reports of Standing Committees consisted of Drs. J. S. Allen, Norwalk, chairman; W. A. Munn, Janesville; R. E. Garrison, Wisconsin Rapids; S. W. Hollenbeck, Milwaukee; J. H. Houghton. Wisconsin Dells. The committee's report follows:

Committee on Cancer.—1. The shift in emphasis from cancer detection centers to examinations conducted in the offices of individual physicians places a special responsibility upon the profession. There is need to acquire all available knowledge on cancer research and experience which can be related to individual practice.

Special skills are needed to acquire an alertness to conditions which might suggest cancer in patients seeking "cancer examinations." The willingness of individuals to come to a physician for a checkup, even though well, should be encouraged and not treated lightly.

Therefore, it is strongly recommended that each physician prepare himself to serve effectively as an individual cancer detection center; that the purposes and limitations of an examination be explained to a patient; that adequate but not excessive charges be made for an examination with emphasis upon cancer detection.

Only by sympathetic approach on the part of the physician can this problem of early detection be met. The public needs sound and practical advice on this subject, and the individual physician is best prepared to give this advice.

2. While physicians are reluctant to speak to lay groups on the subject of cancer, such public contacts are sorely needed to make people aware of their individual responsibilities in preventive phases of this disease. Materials are available to assist with the preparation of such talks. Physicians are urged to assist the members of the Committee on Cancer by indicating their willingness to assist with this important phase of the educational program being carried out.

The reference committee complimented the committee on its splendid report, with special emphasis on its recommendation that: "The shift in emphasis from cancer detection centers to examinations conducted in the offices of individual physicians places a special responsibility upon the profession"; also, that the membership as a whole realize the necessity of accepting this responsibility, and that they can help themselves by acquiring all available knowledge which can be obtained through splendid movies available on detection of cancer.

On motion of Doctor Allen, seconded by Dr. H. E. Kasten, Beloit, carried, this report was accepted.

Committee on Grievances.—The reference committee complimented the Grievance Committee on its report, especially with relation to the Dangerous Drug Act of 1947, and recommended that the solving of this problem be left in the hands of this Grievance Committee, which is to report back to the House next year.

The committee recommended a re-interpretation of the ethics of the American Medical Association as they affect the doctors and the pharmaceutical societies, so that the interests of the patient can best be served.

Because of the trend of the times, it was suggested that a more complete explanation be given to the patient and relatives in respect to the condition under treatment, and that a more complete record be kept in all cases which, in itself, would prevent many complaints.

The committee recommended that each councilor district request some member of the Grievance Committee to appear before it once a year, and, if no such councilor district meeting is held, this opportunity be made available to the individual county societies in that district.

On motion of Doctor Allen, seconded by Dr. M. W. Stuessy, Brodhead, carried, this report was adopted.

Committee on Rural Health and Accident Prevention.—This committee had a very busy and active

year. It should be complimented for the fine work done, and the reference committee recommended the adoption of the four recommendations of the committee.

1. Continuation and improvement of the 4-H Club Health Education program.
2. Establishment of an effective farm safety campaign, including an accident prevention exhibit at the 1951 Farm and Home Week.
3. Greater utilization of scientific programs on brucellosis in county medical societies.
4. Continuation of the Wisconsin Rural Health Conference in 1951.

The reference committee further recommended that exhibits be carried out at the State Fair and other district and local fairs where possible and advisable.

The Health Conference held at Green Lake demonstrated and proved that the rural people look to the medical profession for guidance, and the medical profession must accept that privilege and leadership. The reference committee recommended continuation of this type of conference.

On motion of Doctor Allen, seconded by Dr. H. Kent Tenney, Madison, carried, this report was adopted.

Committee on Coordination of Medical Services.—The reference committee recommended that the report of the Committee on Coordination of Medical Services be approved, and complimented the committee for its very fine presentation.

The reference committee recommended that the committee actually make a study of the fact that the private patient is used for teaching purposes.

On motion of Doctor Allen, seconded by Dr. W. H. Costello, Beaver Dam, carried, this report was adopted.

Committee on Goiter.—The reference committee recommended acceptance of the report and continuation of the program outlined by the Committee on Goiter.

On motion of Doctor Allen, seconded by Dr. C. J. Garding, Jefferson, carried, this report was adopted.

Advisory Committee on the Care of Crippled Children.—The reference committee complimented this committee for its fine report and recommended the adoption of the committee recommendations that:

1. County medical societies encourage their public health nurses and visiting nurses to avail themselves of the opportunity of securing training at the Kiddie Camp for the extension home care nursing of rheumatic fever patients.
2. Continued support be given orthopedic clinics by individual county societies so that services to physicians can be rendered by specialists, who can assist with diagnosis and recommended therapy without disturbing the physician-patient relationship.
3. Physicians assist whenever possible in giving proper medical direction to lay groups concerned with specialized problems in the care of patients suffering from cerebral palsy or epilepsy, so that treatment facilities are not set up without proper medical direction and adequate specialized consultation service directly related to the ailment.

On motion of Doctor Allen, seconded by Dr. H. Kent Tenney, Madison, carried, this report was adopted.

Committee on Health and Public Instruction.—The reference committee recommended the approval of this committee's report, and complimented the committee for its very fine work.

The committee recommended that the House of Delegates recognize the fine public service of the radio stations which are donating their time in carrying the program "The March of Medicine."

On motion of Doctor Allen, seconded by Dr. J. Holden Robbins, Madison, carried, this report was adopted.

Committee on Hearing Defects. The reference committee recommended adoption of the report of this committee. The factual information pertinent to the committee's work was outlined in its report.

On motion of Doctor Allen, seconded by Dr. T. A. Leonard, Madison, carried, this report was adopted.

Committee on Industrial Health.—The reference committee made special mention of the good public relations work that is being done between the Society and industry. It recommended the adoption of the committee's report, with special emphasis on its suggestion of revising literature on the pre-employment examination program which was initially established in 1939.

On motion of Doctor Allen, seconded by Dr. W. H. Costello, Beaver Dam, carried, the report was adopted.

Committee on Medical Education and Hospitals.—The reference committee recommended adoption of this committee report and further recommended that the committee develop a program along with the Committee on Health and Public Instruction, in bringing before the public the problems of medical education.

On motion of Doctor Allen, seconded by Dr. C. J. Garding, Jefferson, carried, this report was adopted.

Committee on Mental Hygiene, Institutional Care, Public Welfare and State Departments.—The reference committee recognized the important work done by this committee in the field of mental hygiene. It

recommended the adoption of the report with the recommendations outlined:

1. That the State Medical Society direct the Committee on Public Policy to again sponsor legislation to meet the needs of the aged by reintroducing a bill similar to that presented to the 1949 legislature, which would permit county infirmaries to be built out of county funds and with state support for care of state patients.
2. That the Department of Public Welfare be encouraged to study the advisability of introducing legislation which will provide for adequate regulation and inspection of nursing and boarding homes, so as to provide a better type of care than is now the case.
3. That more efforts be made by physicians, as members of local hospital staffs, to have at least a minimum of facilities available for the care of the mentally disturbed, before surgical procedures or before being transported to Mendota or Winnebago for treatment. Further, that hospitals of sufficient size to maintain departmental organization be encouraged to establish a psychiatric service to concern itself with prevention as well as treatment in acute cases of neurosis.
4. That local county medical societies give support to the establishment of mental health centers, properly staffed, and under the immediate direction of responsible medical authorities.

On motion of Doctor Allen, seconded by Dr. J. A. Hurlbut, Madison, carried, the report was adopted.

Committee on Public Policy.—The reference committee, on review of the report of the Committee on Public Policy, recommended its approval.

Inasmuch as the coming year will be a legislative year, it emphasized the importance of each individual member of the State Society accepting his responsibility to cooperate in every way possible with the Committee on Public Policy in matters pertaining to legislation.

On motion of Doctor Allen, seconded by Dr. E. L. Bernhart, Milwaukee, carried, the report was adopted.

Committee on Tuberculosis and Chest Diseases.—The report of this committee was recommended for approval, and on motion of Doctor Allen, seconded by Dr. W. H. Costello, Beaver Dam, carried, it was adopted.

Council on Medical Service and Public Relations.—The report of this Council as published was recommended for adoption, including the following points:

1. Development of adequate portable exhibits on prepaid health care plans approved by the Society, and the work and services of the State Medical Society to be used at fairs, conventions, and organizational meetings.
2. Expansion of night and emergency call systems so that where no county or city plan is in operation, arrangements are provided through the staffs of all approved hospitals.
3. Approval of the establishment of a Wisconsin Physicians' Aid Association, to provide aid to needy doctors of medicine in emergency need, and to needy widows and minor children of deceased doctors of medicine.

The reference committee called special attention to the recommendation of the establishment of a Wisconsin Physicians' Aid Association, and recommended that a special detailed study be made of it and a report submitted to the next House of Delegates.

On motion of Doctor Allen, seconded by Dr. C. J. Garding, Jefferson, carried, this report was adopted.

Council on Scientific Work.—The report of this Council was recommended for adoption, and the reference committee called special attention to the further development of the Council's new form of postgraduate teaching.

The committee had referred to it by the House of Delegates, at the suggestion of the Council on Scientific Work, a revision to Section 3, Chapter II of the By-Laws relative to the presentation of papers before the State Medical Society.

The committee recommended the revision in the By-Laws so that the section would read as follows:

"All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Members who read papers before this Society shall not cause them to be published elsewhere until after they have been published in its *Journal* or returned by the Editorial Board. Authors who fail to observe this Section shall be ineligible to appear on programs of the State Society for a period of five years."

It was moved by Doctor Allen, seconded by Dr. A. M. Christofferson, Waupaca, that the report be adopted. Discussion ensued, with regard to amending Section 3, Chapter II of the By-Laws, and the determination was laid over for decision at the third session.

Committee on Maternal and Child Welfare.—The reference committee recommended the adoption of the report of this committee with suggestions of the committee as outlined in its report. There was discussion as to the interpretation of the committee's suggestions, and on motion of Dr. E. L. Bernhart, Milwaukee, seconded by Dr. J. W. Fons, Milwaukee, carried, the House of Delegates asked that this section of the reference committee's report, as well as the preceding section, be held over for resubmission at the third session.

REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS

The Reference Committee on Resolutions and Amendments to the Constitution and By-Laws was composed of Drs. Norbert Enzer, Milwaukee, chairman; R. E. Garrison, Wisconsin Rapids; W. A.

Munn, Janesville; S. W. Hollenbeck, Milwaukee; and J. H. Houghton, Wisconsin Dells.

The committee offered the following recommendations:

Resolution to Create Section on Obstetrics and Gynecology.—The committee recommended adoption of this resolution, with the formal organization of the Section, including the election of officers and a delegate, to be taken during the course of this annual meeting.

On motion of Doctor Enzer, seconded by Dr. J. W. Fons, Milwaukee, carried, the resolution was adopted.

Resolution to Require that Candidates for Speaker and Vice-Speaker be Members of the House and Full Dues-Paying Members.—The committee noted that under Article IX, Section 1 of the Constitution of the State Medical Society, the Speaker and Vice-Speaker are officers of the Society as a whole, and therefore are not limited as officers of the House of Delegates.

The committee recommended rejection of this resolution, as it could not recognize that the Society as a whole stands to benefit by limiting the range of selection of a Speaker and Vice-Speaker to the House of Delegates. The committee felt that the Society would deprive itself of the opportunity to obtain the services of many able men, who, at the time of their selection as such officers as covered by this resolution, are not delegates, yet who are actively interested in the Society as a whole.

On motion of Doctor Enzer, seconded by Dr. J. Holden Robbins, Madison, carried, the resolution was rejected.

Report of Committee on Hospital Relations and Resolution on Hess Report.—The reference committee reviewed the resolution introduced by the Section on Radiology on the Hess Report, as published on page 1188 together with the following report of the Committee on Hospital Relations:

The Committee on Hospital Relations stands ready to function should any complaints be furnished it as to hospital procedures which would not come within the province of the Committee on Grievances. The committee requests that its status be continued for at least another year to see if it can be of service to the Society as an individual body functioning in such fields as recently considered by the American Medical Association in its action on the subject of professional services and the hospital.

This committee has not met for the past year, and so has little to report. There has been no clear delineation of functions of this particular committee, since it ceased to prepare a section program for the Annual Meeting. Two years ago it conducted a hospital relations conference of hospital personnel and physicians in Green Bay, but the results of the meeting were not too satisfactory. While there was a good attendance of nurses and hospital administrators, the physicians showed little interest by way of participating in the program. In light of this situation the committee has not attempted to develop further meetings of this character.

The reference committee noted that the resolution introduced by the Section on Radiology endorsed action of the American Medical Association House of Delegates in adopting the report of the Committee on Hospitals and the Practice of Medicine, known as the Hess Report, and charged the Committee on Hospital Relations of the State Medical Society with the further duty of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems involving the practice of medicine in hospitals.

It further provided that if the matter cannot be arbitrated by the Committee on Hospital Relations, its judgment to that effect, with its findings and recommendations, be transmitted to the Council of the Society for its suitable recommendations to the Judicial Council of the American Medical Association.

On motion of Doctor Enzer, seconded by Dr. C. J. Garding, Jefferson, carried, the resolution of the Section on Radiology was adopted.

The committee further recommended that the report of the Committee on Hospital Relations be approved, and on motion of Doctor Enzer, seconded by Dr. J. W. Fons, Milwaukee, carried, the report was approved.

Resolution to Redistrict the State for Selection of Councilors.—This resolution was introduced at the 1948 meeting of the House of Delegates and was held over from the 1949 annual meeting. The reference committee recommended rejection of the resolution on the grounds that the present method of selecting councilors affords a more satisfactory representation of physician population.

On motion of Doctor Enzer, seconded by Dr. C. O. Schaefer, Racine, carried, the resolution was rejected.

Dues for 1951.—After a review of the budget, as well as projects of the Society, the reference committee recommended that dues be maintained at the present level, inasmuch as, barring unforeseen contingencies, the present dues enable the Society to set aside a small percentage for reserves. In addition, in view of some uncertain variables of the total dues collection during a period when some members of the Society may be in military service, and other factors, the committee stressed the importance of all members paying their dues to the State Society.

On motion of Doctor Enzer, seconded by Dr. E. C. Cary, Reedsville, carried, dues were retained at $50 for the ensuing year.

Wisconsin Physicians Service.—The detailed report of the Wisconsin Physicians Service Directing Board was reviewed, and the reference committee recommended its adoption.

On motion of Doctor Enzer, seconded by Dr. H. E. Kasten, Beloit, carried, the report was adopted.

Special Council Report on Insurance Plans.—The reference committee believed that this proposal should be approved. It urged that the Council proceed without delay in the development of plans for the presentation of these reports to a special session of the House of Delegates, and that such a special session be called at the earliest convenient time.

In considering the Council's report, the committee realized that the problem of the fee schedule is one of paramount importance to both the purchaser of the policy and the physician. It also realized that there are many other phases of the insurance programs which give rise to dissatisfaction, and felt that opportunity should be provided to review all matters of that nature in a special session of the House of Delegates.

This committee recommended that the Council, in pursuing its plans for the program of the special session of the House, invite the appropriate reference committee of the State Medical Society to join with the Council in formulating the plans and details for this meeting.

It was the committee's recommendation that when the Council requests the various specialty groups to select a representative to serve on the special fee schedule committee, it should supply these specialty groups with information which will make it possible for each group to select a physician who can serve to the fullest extent, having in mind, among other things, his constant availability.

In preparing material for a special session of the House, the reference committee recommended that the Council advise all members of the Society that all matters pertaining to health insurance plans will be properly considered.

It also suggested that the committees already existing in these plans should be prepared to present their programs and to meet various questions that might be brought up at this special session.

It further recommended that the entire membership of the Society be invited to contribute its comments, queries, criticisms, and so forth, to the Council or the committees working with the Council.

The reference committee recognized the manifold problems surrounding the Society's insurance plans, and that the only way they can be met is by progressively working them out through adequate committee and specialized studies.

On motion of Doctor Enzer, seconded by Dr. J. K. Trumbo, carried, the report was adopted.

Resolutions on Insurance.—In considering the five resolutions introduced by Doctor Hughes, the reference committee was of the opinion that these resolutions involve technical features of management of insurance plans, and several of the recommendations embodied in the resolutions are already under study by an actuary.

Whereas the committee did not feel that it had presented to it, or had available through its own resources, material sufficient for a critical analysis of these resolutions, and whereas most of the recommendations embodied in these resolutions were already in effect or under study, and whereas the committee had recommended the adoption of the Council report to the House of Delegates indicating an opportunity for a full scale review of these problems to be presented in detail at a special meeting of the House of Delegates, the committee recommended the rejection of these resolutions at this time.

On motion of Doctor Enzer, seconded by Dr. J. Holden Robbins, Madison, carried, the resolutions were rejected.

On motion of Doctor Enzer, seconded by Dr. J. W. Fons, Milwaukee, carried, the report of the Resolutions Committee as a whole was adopted.

REPORT OF THE FACT-FINDING COMMITTEE

The Fact-Finding Committee was composed of Drs. P. B. Mason, Sheboygan, chairman; A. A. Cantwell, Shawano; R. F. Purtell, Milwaukee; and G. J. Schulz, Union Grove.

The committee reported that numerous questions were asked, most of which applied to prepaid voluntary types of insurance. It seemed to the committee that there was a general lack of interest and apathy in the medical profession in bringing out constructive criticism at the proper time and place.

There was a long and detailed discussion with Mr. Tiffany, the actuary who had been hired by the State Society, and it seemed to this committee that it would be premature to try to solve the problem of prepaid voluntary plans any further at this time, but to wait until a future report comes in from the Council as to the results of Mr. Tiffany's studies.

It seemed to this committee that the policy-making body of this Society, the House of Delegates, should meet twice a year, and therefore the following resolution was presented:

Resolved: That Chapter III, Section 1 of the By-Laws of the Society be amended to read:

" 'The House of Delegates shall meet at the time and place of the annual session. *It shall also meet between March 15 and April 30 of each year, the time and place to be determined by the Council, where these have not been determined by the House.*' "

Finally, it was recommended that this committee be given permission by the House of Delegates to continue to be active for a period of one year, to further the study of medical problems.

On motion of Dr. J. K. Trumbo, Wausau, seconded by Dr. J. Holden Robbins, Madison, carried, action on the amendment to the By-Laws was postponed until Tuesday.

On motion of Dr. P. B. Mason, Sheboygan, seconded by Dr. J. H. Houghton, Wisconsin Dells, carried, the report of the Fact-Finding Committee was accepted, with the exception of the amendment to the By-Laws.

On motion of Dr. E. C. Cary, Reedsville, variously seconded, carried, the House of Delegates asked that flowers and a message of sympathy and best wishes be sent to Speaker Stewart from the House of Delegates.

Recess

The House of Delegates recessed at 5:15 p. m. to reconvene its second session at 9:00 a. m. Tuesday.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS

This reference committee, composed of Drs. C. E. Zellmer, Antigo, chairman; E. C. Cary, Reedsville; and W. H. Costello, Beaver Dam, presented the following report:

Report of the President.—The report of President Truitt was reviewed, and the committee concurred in the president's opinion that the time and energy spent by the Council and officers of the Society, as well as the Interim Committee and other committees of the Society, cannot be measured. It was appreciative of the fact that all committees have given a good deal of thought and effort to the duties assigned to them, and reaffirmed the president's opinion that there are no problems which face the medical profession which cannot be solved by the American way, voluntarily, in an orderly, progressive, majority rule manner.

On motion of Doctor Zellmer, seconded by Dr. J. W. Fons, Milwaukee, carried, the president's report was accepted.

Report of the Speaker.—The committee considered the report of Speaker Stewart, as presented by Vice-Speaker MacCornack and recommended its adoption.

On motion of Doctor Zellmer, seconded by Dr. F. E. Drew, Milwaukee, carried, the report was adopted.

Report of the President-Elect.—The report of the president-elect, Dr. H. H. Christofferson, contained a recommendation to the House of Delegates that it authorize a loan fund for those who need assistance in financing a medical education. The reference committee recommended that the Council be authorized to study such a program, and establish such a fund if it is found feasible to do so.

On motion of Doctor Zellmer, seconded by Dr. H. E. Kasten, Beloit, carried, the report was adopted.

Report of the Treasurer.—The report of the treasurer was accepted, with the recommendation that the insurance items be further broken down in the next treasurer's report to show the cost incurred by each insurance program.

On motion of Doctor Zellmer, seconded by Dr. J. A. Enright, Milwaukee, carried, the report was accepted.

Report of the Delegates to the American Medical Association.—This report was published in the *Wisconsin Medical Journal* and sent to each member of the Society. The committee recommended its approval, and on motion of Doctor Zellmer, seconded by Dr. W. R. Berg, Gillett, carried, the report was approved.

Resolution Regarding Selection of Reference Committees.—Inasmuch as two of the members appointed to this reference committee were unable to attend the Monday morning session, as they were members of the Committee on Nominations, it was felt that provision should be made to avoid delay in consideration of the matters referred to any reference committee in the future, by the adoption of the following resolution:

WHEREAS, the policy of the Society now calls for the consideration and study of resolutions, officers' reports, actions, and other proposals by appropriate reference committees, and it becomes a practical necessity for such committees to make analyses and to study the problems presented for the entire House within a time limitation, and

WHEREAS, it is impossible for reference committees to muster a quorum or to conduct a study with a proper degree of thoroughness unless the members of such committees are available throughout these deliberations;

Now, therefore, be it resolved: That the Speaker and the House of Delegates be invited to avoid the selection of the same delegate for more than one committee during the course of any session of the House of Delegates, so as to make him available to the extent necessary for the committee to which he was named.

On motion of Doctor Zellmer, seconded by Dr. M. W. Stuessy, Brodhead, carried, the resolution was approved.

Report of the Council.—The committee reviewed the extensive report of the Council and its committees as well as its supplementary report to the House of Delegates.

On motion of Doctor Zellmer, seconded by Dr. L. O. Simenstad, Osceola, the report of the Council as published in the Delegates' Handbook was approved.

The supplementary report of the Council and its several resolutions were presented for consideration. One of the resolutions commended the radio stations which carry the "March of Medicine" radio programs; another commended the newspapers of the state, and another proposed an amendment to the By-Laws to provide for a minimum of five-man committees unless otherwise indicated in the By-Laws. The committee recommended the adoption of the supplementary report and these resolutions.

On motion of Doctor Zellmer, seconded by Dr. C. O. Schaefer, Racine, carried, the supplementary report and resolutions were approved.

Resolution on Group Malpractice Insurance.—The resolution relating to a study of group malpractice insurance, to be conducted by the Committee on Group Insurance was recommended for approval and for commitment to the Committee on Group Insurance. In doing so, the reference committee suggested the importance of keeping in mind at all times the highly personal character of this subject to the individual practitioner, the marked variations and the

conditions and extensive coverage as well as the cost of this coverage to the individual. The reference committee felt it essential that any over-all study give proper weight to each of the factors which are important to physicians individually as well as to a group.

On motion of Doctor Zellmer, seconded by Dr. F. E. Drew, Milwaukee, carried, the study of group malpractice insurance was referred to the Committee on Group Insurance.

Resolutions on Hospital Standardization and Membership in the Society, and the Report of the Committee on Military Medical Service.—The first resolution provided that the House of Delegates express to the American Medical Association its complete support of its program in the field of standardization of hospitals for the purpose of intern and residency opportunities.

The second resolution was a proposed amendment to the Constitution, to provide that membership in the American Medical Association be obligatory upon all those who wish to be members of their county and state medical society in Wisconsin.

The third was the report of the Committee on Military Medical Service.

The reference committee recommended adoption of the two resolutions and the report of the Committee on Military Medical Service.

On motion of Doctor Zellmer, seconded by Dr. H. E. Kasten, Beloit, carried, the two resolutions and the report of the Committee on Military Medical Service were adopted. On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. W. H. Costello, Beaver Dam, carried, an amendment was approved to provide that the resolution on dues become effective January 1, 1951, so that no problem would be created in billing current members.

Veterans Medical Service Agency.—The reference committee considered the following financial report of the Veterans Agency:

FINANCIAL REPORT OF WISCONSIN VETERANS MEDICAL SERVICE AGENCY

Total value of business with the Veterans Administration from November 1, 1946 through August 15, 1950

Total value of authorizations received from Veterans Administration		$1,326,935.33
Total value of authorizations cancelled		110,001.90
Total value of unused authorities		183,760.01
Total value of claims filed with Veterans Administration		1,053,247.69
Total cash disbursed to physicians	$946,985.80	
Total administrative expense received from Veterans Administration	98,127.23	
Total cash received from Veterans Administration		1,045,113.03

Certified Financial Statement
June 30, 1950

Assets			
Current Assets			
Cash in Bank—Administrative Fund	$ 3,837.78		
Cash in Bank—Medical Fund	$ 6,164.70		
Petty Cash	10.00		
Medical Claims Filed with Veterans Admin.	14,031.55		
Administrative Claim Filed with Veterans Admin.	1,981.85		
Total Current Assets		$	26,025.88
Fixed Assets			
Office Furniture and Fixtures	$ 2,546.04		
Less: Accumulated Depreciation	946.15		
Total Fixed Assets			1,599.89
Prepaid Expenses			
Unexpired Insurance			42.48
Total Assets		$	27,668.25
Liabilities			
Current Liabilities			
Due Doctors on Claims Filed	$ 20,193.75		
Due Veterans Administration	2.75		
Total Liabilities			20,196.50
Advance from State Medical Society of Wisconsin			
Balance of Cash Advanced—January 1, 1950	7,500.00		
Non-recoverable Expenditures			
Balance — Jan. 1, 1950	$28.00		
Expended — Jan. 1, 1950—June 30, 1950	.25		
Balance—June 30, 1950	28.25		
Total Advance—June 30, 1950		$	7,471.75

Certificate

I have audited the accounts of the Wisconsin Veterans Medical Service Agency, an agency of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period January 1, 1950 to June 30, 1950, and

I hereby certify that, in my opinion, the above Financial Statement and related Statement of Income and Expenditures correctly represent the financial condition of the Agency on June 30, 1950 and the result of its operations for the period January 1, 1950 to June 30, 1950, in conformity with generally accepted accounting principles.

/S/ Donald E. Gill
Certified Public Accountant

Madison, Wisconsin
July 11, 1950

On motion of Doctor Zellmer, seconded by Dr. C. O. Schaefer, Racine, carried, the report was adopted.

Report of the Secretary.—The committee noted that the report of the secretary summarized developments within the State Medical Society during the past year, and recommended its adoption.

On motion of Doctor Zellmer, seconded by Dr. R. E. Garrison, Wisconsin Rapids, carried, the report was adopted.

Report of the State Health Officer.—The reference committee was of the opinion that developments in activities on civil defense should be followed with interest and recommended adoption of the report of the state health officer.

On motion of Doctor Zellmer, seconded by Dr. F. E. Drew, Milwaukee, carried, the report was adopted.

On motion of Doctor Zellmer, seconded by Dr. E. C. Cary, Reedsville, carried, the report of the Reference Committee on Reports of Officers was adopted as a whole.

STATEMENT ON MEETING WITH POLITICAL CANDIDATES ADOPTED

Following the Monday night session of the House of Delegates, a meeting was held at which candidates for the office of United States senator, congressmen, and governor of the state were invited to address the membership. At this time, Dr. R. G. Arveson, Frederic, made the following statement to the House of Delegates for its consideration:

Mr. Chairman and gentlemen, last night we listened to the candidates for several offices in this state, and I think you became aware, after a few moments, of just what they thought of you.

I have said many times that if we have socialized medicine in this country, probably one of the factors which will bring it about is the indifference of the physician. He has a great tendency to destroy himself.

In the flux of thinking just previous to the Revolutionary War, in Philadelphia there was a minister by the name of Muehlenberg. He appeared before his congregation with his clerical robes on; then he said, "There is a time to pray and a time to fight." And stripping off his clerical robes, he stood there in the uniform of an officer of the Continental Army.

I, for one, believe in fighting. And so I would like to read this to you, and trust that you will adopt it, after listening to the political candidates last night:

"Shall the federal government regiment all essential services of this country? Two candidates, Andrew J. Biemiller and Thomas E. Fairchild, speaking at a Candidates' Forum at the meeting of the State Medical Society, in Milwaukee, make it clear that the proud American way of voluntary systems, free from compulsion, will be destroyed in this country if their views are to prevail.

"That is the road to socialism. It cannot and will not stop with medicine.

"Any person, proud of this country, proud of its record, proud to be a citizen, should rightfully now force the issue.

"Are the skilled trades—electricians, plumbers, carpenters—to become the servants of the state?

"Is collective bargaining to be abolished and government dictatorship to be substituted?

"Is the farmer to become an economic peasant in this planned society?

"Shall the professions of law, medicine, engineering, and others be the exclusive services of bureaucratic government?

"Shall the business services—housing, merchandising and banking—be government monopolies?

"Voluntary efforts, as they exist today, were ridiculed and held to be ineffective and unworkable. It is useless to fight communism and socialism in Korea, only to lose the fight at home.

"Forceful opposition was expressed by candidates Charles Kersten and Vernon W. Thomson. The State Medical Society agrees with their conclusions. It agrees that the history of the movement is the result of long-time socialist planning. It agrees that American citizenship must be preserved.

"It agrees that the issue is here, and that the fight is on. It pledges its support to the philosophy that a government of the people, by the people, and for the people must be preserved."

On motion, variously seconded and passed, this statement was adopted by the House of Delegates.

REJECTION OF AMENDMENT TO BY-LAWS TO PROVIDE FOR TWO SESSIONS OF THE HOUSE

The amendment to the By-Laws, proposed by the Fact-Finding Committee, for the purpose of providing for two sessions of the House of Delegates was further considered at this time.

Dr. J. K. Trumbo, Wausau, stated that such an amendment to the By-Laws would make it mandatory to fix a certain time for the House to meet which would be awkward, as there is no assurance that the actuary of the Society might not bring in his report after the time limit. Secondly, a provision already exists in Article VIII, Section 3 of the Constitution which provides for the calling of special meetings of either the Society or the House of Delegates, on two-thirds vote of the Council, or upon petition of twenty delegates.

On motion of Doctor Trumbo, seconded by Dr. E. D. Sorenson, Elkhorn, the amendment was rejected.

THIRD SESSION

Tuesday, October 3, 1950

The third session of the House of Delegates convened immediately, Dr. R. L. MacCornack, Vice-Speaker of the House, presiding.

Report of Committee on Credentials

The Committee on Credentials verified the registration of 61 delegates and 11 alternate delegates entitled to vote at this session of the House of Delegates. In addition, seven alternate delegates and five councilors registered their attendance.

The Committee on Credentials also advised that Dr. N. A. Hill, Madison, was authorized to act as a specially appointed delegate from Dane County in place of a delegate unable to attend.

It was moved by Doctor Schaefer, seconded by Dr. E. C. Cary, Reedsville, and carried, that the

attendance roll of delegates, alternate delegates, and the specially appointed delegate, totalling 73, be accepted as the official roll of this session of the House to stand for the entire session.

Report of Committee on Nominations

The names of the following nominees were presented for official positions in the State Medical Society:

For President-elect: Dr. A. H. Heidner, West Bend

For Speaker of the House: Dr. R. L. MacCornack, Whitehall

For Vice-Speaker of the House: Dr. B. J. Hughes, Winnebago

For Delegates to the American Medical Association: Dr. S. E. Gavin, Fond du Lac; and Dr. Dexter Witte, Milwaukee

For Alternate Delegates to the A. M. A.: Dr. L. O. Simenstad, Osceola; and Dr. J. C. Griffith, Milwaukee

Milwaukee was the choice for the next state meeting.

On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. W. H. Costello, Beaver Dam, carried, the report of the Nominating Committee was accepted.

On motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. J. K. Trumbo, Wausau, carried, Doctor Heidner was unanimously elected to the office of president-elect.

On motion of Dr. H. E. Kasten, Beloit, seconded by Dr. E. C. Cary, Reedsville, carried, Doctor MacCornack was unanimously elected as Speaker of the House. President Truitt presided at this election.

On motion of Dr. Leo Hudson, Lancaster, seconded by Dr. E. C. Cary, Reedsville, Doctor Hughes was unanimously elected as Vice-Speaker of the House.

On motion of Dr. H. Kent Tenney, Madison, seconded by Dr. O. W. Saunders, Green Bay, carried, Doctor Gavin was unanimously re-elected as delegate to the American Medical Association.

On motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. J. K. Trumbo, Wausau, carried, Doctor Simenstad was re-elected as alternate delegate to the A. M. A.

On motion of Dr. E. L. Bernhart, Milwaukee, seconded by Dr. W. T. Casper, Milwaukee, carried, Doctor Witte was elected as delegate to the A. M. A.

On motion of Dr. F. E. Drew, Milwaukee, seconded by Dr. J. W. Fons, Milwaukee, Doctor Griffith was elected as alternate delegate to the A. M. A.

On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. C. O. Schaefer, Racine, Milwaukee was selected as the place for the 1951 meeting.

ELECTION OF COUNCILORS

The House then proceeded to the election of councilors with the following results:

In the Seventh District, on motion of Dr. H. E. Kasten, Beloit, seconded by Dr. T. F. Farrell, Prairie du Chien, carried, Dr. J. C. Fox, La Crosse, was re-elected.

In the Eighth District, on motion of Dr. A. A. Cantwell, Shawano, seconded by Dr. W. R. Berg, Gillette, carried, Dr. J. M. Bell, Peshtigo, was re-elected.

In the Ninth District, on motion of Dr. A. M. Christofferson, Waupaca, seconded by Dr. J. K. Trumbo, Wausau, carried, Dr. E. E. Kidder of Stevens Point was elected.

In the Tenth District, on motion of Dr. J. H. Wishart, Eau Claire, seconded by Dr. J. J. Sazama, Chippewa Falls, carried, Dr. R. G. Arveson, Frederic, was re-elected.

In the Thirteenth District, on motion of Dr. G. E. Carroll, Laona, seconded by Dr. I. E. Schiek, Sr., Rhinelander, carried, Dr. C. E. Zellmer, Antigo, was elected.

ACCEPTANCE OF THE PRESIDENT-ELECT

Vice-Speaker MacCornack appointed a special committee composed of Drs. E. C. Cary, E. W. Humke, and F. I. Bush to escort the president-elect, Dr. A. C. Heidner to the platform. In his speech of acceptance, Doctor Heidner included the following remarks:

This is an honor that I have never striven for, and a position I never expected to fill. I have sat in the fringe of the inner circle of medical administration in Wisconsin for a long time. As the years of service and experience have accumulated, I have been drawn closer and closer to the center of things, until now I have been pushed to the top.

I have been told that my nomination to this office was unanimous, but that it was a compromise between men representing opposing ideas concerning medical government.

Doctors are grand people, but their peculiar type of personalities, and the nature of their training and work, makes it easy for them to give orders and difficult for them to take them. It is often hard to persuade the minority group to conform to and abide by the decisions of the majority.

Now, our new problem appears to be the age-old problem of youth against age, of the new versus the old, and in this instance a demand for more decentralization of power in medical administration and control; this, at a time when centralization in everything else is tightening its hold to a point near strangulation of individual effort and freedom.

It is a challenge worthy of most careful consideration and study. I accept the challenge, and will do the best I can with it.

CONTINUATION OF REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Committee on Maternal and Child Welfare (continued).—Doctor Allen, chairman of this reference committee, stated that the committee had reviewed with care the report of the Committee on Maternal

and Child Welfare, and approved the report, with the following additions and points of emphasis:

1. With increased public interest in the subjects of rooming-in and natural childbirth, it is recommended that hospital staffs and individual physicians study these questions so as to better advise their patients. It is recognized that the matter of rooming-in involves hospital administrative problems, which can best be evaluated by combined study of physicians affiliated with hospital staffs and hospital administrators. The development of this program is one of evaluating facilities on a local level, and establishing procedures which are medically sound and in the best interests of the patients served.

The question of natural childbirth is receiving increased attention in the lay press, and it is recommended that it, as well as rooming-in, be studied with care. Because there is no unanimity of opinion on this question among physicians at the present time, the committee suggested further study of this question.

2. Continued emphasis should be placed upon intensified programs of postgraduate education in the fields of obstetrics and pediatrics. The committee report outlined briefly the circuit teaching program instituted by the State Medical Society in cooperation with the State Board of Health. It was recommended that these programs be expanded, and that they be supplemented by more postgraduate courses given through the Council on Scientific Work in the form of special teaching clinics offered in cooperation with the two medical schools.

3. The previous reports of the Committee on Maternal and Child Welfare have called attention to the high incidence of cesarean sections performed in certain localities. It has been previously recommended that hospital staffs establish regulations so that surgical procedures in relation to delivery will have the value of consultation by some recognized physician in the community who has no direct relation with the case involved. It was suggested that medical staffs of hospitals appraise their present rules governing this matter, and establish regulations which will best serve the interest of the patients.

4. With the increase in the armed forces there is a strong possibility that efforts will be made to reenact legislation which will provide federal assistance to wives of service men, such as set forth in the EMIC program during World War II. It was strongly recommended that the American Medical Association be urged to keep the states informed as to impending legislation in this field so that efforts can be exerted to avoid some of the unfortunate experiences of the former program.

On motion of Doctor Allen, seconded by Dr. T. A. Leonard, Madison, carried, this report was adopted.

Council on Scientific Work (continued).—The secretary's office was asked to provide an appropriate amendment having to do with the furnishing of scientific papers. On motion of Doctor Allen, seconded by Dr. J. K. Trumbo, Wausau, carried, Chapter II, Section 3, of the By-Laws was amended to include the following sentence: "The Council shall establish rules relating to requiring written papers of speakers."

On motion of Doctor Allen, seconded by Dr. O. W. Saunders, Green Bay, carried, the report of the Reference Committee on Reports of Standing Committees was accepted as a whole.

Letter to Mr. Vernon Thomson

It was suggested that the House of Delegates authorize a letter to Mr. Vernon Thomson, who spoke at the Monday night meeting in place of Senator Alexander Wiley. On motion of Dr. F. L. Weston, Madison, seconded by Dr. E. E. Kidder, Stevens Point, carried, the secretary was instructed to write a letter to Mr. Thomson with regard to the interruption of his talk at the Monday night meeting.

Adjournment Sine Die

On motion of Dr. J. K. Trumbo, Wausau, seconded by Dr. F. E. Drew, Milwaukee, carried, the House of Delegates adjourned, sine die at 10:45 a.m.

NEW ORLEANS GRADUATE MEDICAL ASSEMBLY TO BE HELD IN MARCH

The fourteenth annual meeting of the New Orleans Graduate Medical Assembly will be held March 5–8, headquarters at the Municipal Auditorium, in New Orleans.

Nineteen guest speakers will present papers of interest to both specialists and general practitioners. The program will include a panel discussion on ACTH and Cortisone, a series of talks on trauma and neoplastic disease, a review of the application of radioactive isotopes in medical practice, clinicopathologic conferences, round-table luncheon discussions, and many other features of special interest. Daily demonstrations of medical and surgical procedures in color television, telecast from Charity Hospital to the auditorium, will be sponsored by Smith, Kline & French Laboratories.

The Assembly has planned another interesting postclinical tour to follow the 1951 meeting in New Orleans. On Saturday, March 10, a party composed of doctors and their families will leave by plane for Panama. The itinerary also includes Medillin and Cali, Colombia; Quito, the capital of Ecuador and Lima, Peru. Medical programs and visits to hospitals have been arranged, together with a full schedule of sightseeing. The group will return to New Orleans on Sunday, March 25. Details and a complete itinerary are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Attendance at House of Delegates, Milwaukee October 1, 2, 3, 1950

Society	Delegate	Sessions 1	2	3
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	x	x	x
	J. E. Kreher, Ashland*	a	a	a
	W. E. Bargholtz, Ashland (Proxy for alternate delegate)	x	x	a
Barron–Washburn–Sawyer–Burnett	N. A. Eidsmoe, Rice Lake	a	a	x
	G. A. Fostvedt, Barron*	a	a	a
Brown–Kewaunee–Door	O. W. Saunders, Green Bay	x	x	x
	E. M. Jordan, Green Bay*	a	a	a
	W. A. Killins, Green Bay	x	x	x
	L. D. Quigley, Green Bay*	a	a	a
Calumet	E. W. Humke, Chilton	x	x	x
	A. C. Engel, New Holstein*	a	a	a
Chippewa	J. J. Sazama, Chippewa Falls	x	x	x
	S. E. Williams, Chippewa Falls*	x	x	a
Clark	M. V. Overman, Neillsville	x	x	x
	H. H. Christofferson, Colby*	x	x	x
Columbia–Marquette–Adams	J. H. Houghton, Wisconsin Dells	x	x	x
	R. F. Inman, Montello*	x	x	x
Crawford	T. F. Farrell, Prairie du Chien	x	x	x
	H. E. Oppert, Gays Mills*	a	a	a
Dane	T. A. Leonard, Madison	x	x	x
	N. A. Hill, Madison*	x	x	x**
	A. T. Smedal, Stoughton	x	a	x
	H. L. Greene, Madison*	a	a	a
	J. H. Robbins, Madison	x	x	a
	T. W. Torney, Jr., Madison*	a	a	a
	H. K. Tenney, Madison	x	x	x
	L. V. Sprague, Madison*	a	x	x
	A. S. Jackson, Madison	a	a	a
	J. S. Hurlbut, Madison*	x	x	x
Dodge	W. H. Costello, Beaver Dam	x	x	x
	A. B. Kores, Beaver Dam*	a	a	a
Douglas	Charles W. Giesen, Superior	x	x	x
	H. B. Christiansen, Superior*	x	x	a
Eau Claire–Dunn–Pepin	J. H. Wishart, Eau Claire	x	x	x
	O. G. Moland, Augusta*	x	x	x
Fond du Lac	D. J. Twohig, Fond du Lac	a	a	x
	D. N. Walters, Fond du Lac*	x	x	x
Forest	G. E. Carroll, Laona	x	x	x
	O. S. Tenley, Wabeno*	a	a	a
Grant	Leo Hudson, Lancaster	x	x	x
	E. C. Howell, Fennimore*	a	a	a
Green	M. W. Stuessy, Brodhead	x	x	x
	L. G. Kindschi, Monroe*	a	a	a
Green Lake–Waushara	G. C. Stone, Berlin	x	x	a
	H. C. Koch, Berlin*	a	a	a
Iowa	C. L. White Mineral Point	x	x	a
	E. J. Hohler, Mineral Point*	a	a	x
Jefferson	C. J. Garding, Jefferson	x	x	x
	F. A. Gruesen, Fort Atkinson*	a	x	x
Juneau	C. A. Vogel, Elroy	a	a	a
	J. S. Hess, Mauston*	x	x	x
Kenosha	D. N. Goldstein, Kenosha	x	x	x
	L. H. Lokvam, Kenosha*	x	a	a
La Crosse	F. H. Wolf La Crosse	a	x	x
	P. V. Hulick, La Crosse*	a	a	a
	J. C. Fox, La Crosse (Proxy for alternate delegate)	x	x	x
Lafayette	L. L. Thompson, Argyle	x	x	a
	D. J. Garland, Shullsburg*	a	a	a
Langlade	C. E. Zellmer, Antigo	x	x	x
	W. P. Curran, Antigo*	x	x	x
Lincoln	R. G. Baker, Tomahawk	x	x	x
	K. A. Morris, Merrill*	x	x	x
Manitowoc	E. C. Cary Reedsville	x	x	x
	E. W. Huth, Valders*	a	a	a
Marathon	J. K. Trumbo, Wausau	x	x	x
	H. H. Stevens Wausau*	a	a	a
Marinette–Florence	K. G. Pinegar, Marinette	x	x	x
	C. E. Koepp, Marinette*	x	x	x
Milwaukee	D. V. Elconin, Milwaukee	a	a	a
	J. B. Wilets, Milwaukee*	x	x	x
	R. F. Purtell, Milwaukee	a	a	a
	C. W. Harper, Milwaukee*	a	x	x
	J. A. Enright, Milwaukee	x	x	x
	Ervin Hansher, Milwaukee*	x	x	x
	W. T. Casper, Milwaukee	x	x	x
	P. J. Niland, Milwaukee*	a	a	a
	T. J. Aylward, Milwaukee	x	x	x

* Indicates alternate delegate.

** Certified as delegate for third session in place of Doctor Robbins.

Society	Delegate	Sessions 1	2	3
	A. J. Baumann, Milwaukee*	x	x	x
	D. F. Pierce, Hales Corners	a	a	a
	J. W. Rastetter, Milwaukee*	x	x	x
	S. W. Hollenbeck, Milwaukee	x	x	x
	E. R. Daniels, Milwaukee*	a	a	a
	S. K. Pollack Milwaukee	a	a	a
	M. W. Shutkin, Milwaukee*	x	x	x
	S. A. Morton, Milwaukee	a	a	a
	C. A. Fortier, Milwaukee*	x	x	x
	E. L. Bernhart, Milwaukee	x	x	x
	J. G. Garland, Milwaukee*	a	a	a
	L. J. Schneeberger, Milwaukee	x	a	x
	H. P. Maxwell, Milwaukee*	a	x	a
	J. V. Herzog, Milwaukee	x	a	x
	J. D. Charles, Milwaukee*	a	x	a
	F. E. Drew, Milwaukee	x	x	x
	L. J. Schwade, Milwaukee*	x	x	x
	Norbert Enzer, Milwaukee	x	x	x
	Joseph Shaiken, Milwaukee*	x	a	a
	W. J. Houghton, Milwaukee	x	x	x
	P. J. Purtell, Milwaukee*	a	a	a
	J. W. Fons, Milwaukee	x	x	x
	G. S. Kilkenny, Milwaukee*	a	a	a
	M. C. Borman, Milwaukee	a	a	a
	H. N. Dricken, Milwaukee*	a	a	a
	M. J. Kuhn, Milwaukee	a	a	a
	C. F. Conroy, Milwaukee*	a	a	a
Monroe	J. S. Allen, Norwalk	x	a	a
	G. C. Devine, Ontario*	x	x	x
Oconto	W. R. Berg, Gillett	x	x	x
	A. F. Slaney, Oconto*	a	a	a
Oneida–Vilas	I. E. Schiek, Sr., Rhinelander	a	x	x
	R. A. Oldfield, Eagle River*	a	a	a
Outagamie	G. W. Carlson, Appleton	x	x	x
	E. F. Mielke, Appleton*	x	x	a
Pierce–St. Croix	C. E. McJilton, River Falls	x	x	x
	O. H. Epley, New Richmond*	a	a	a
Polk	L. O. Simenstad, Osceola	x	x	x
	V. C. Kremser, Amery*	a	x	x
Portage	E. E. Kidder, Stevens Point	x	x	x
	F. E. Gehin, Stevens Point*	a	a	a
Price–Taylor	J. D. Leahy, Park Falls	x	x	x
	J. L. Murphy, Park Falls*	a	a	a
Racine	Carl O. Schaefer, Racine	x	x	x
	G. N. Gillett, Racine*	a	a	a
	G. J. Schulz, Union Grove	x	x	x
	E. J. Schneller, Racine*	a	x	x
Richland	D. H. Hinke, Richland Center	x	x	x
	R. E. Housner, Richland Center*	a	a	a
Rock	H. E. Kasten, Beloit	x	x	x
	W. T. Clark, Janesville*	x	x	x
	W. A. Munn Janesville,	x	x	x
	R. A. Thayer, Beloit*	x	x	x
Rusk	L. M. Lundmark, Ladysmith	a	a	a
	Woodruff Smith, Ladysmith*	x	x	x
Sauk	J. F. Moon, Baraboo	a	a	a
	J. J. Rouse Reedsburg*	x	x	x
Shawano	A. A. Cantwell, Shawano	x	x	x
	E. E. McCandless, Wittenberg*	x	x	x
Sheboygan	P. B. Mason, Sheboygan	x	x	x
	J. A. Russell, Random Lake*	x	x	a
Trempealeau–Jackson–Buffalo	H. A. Jegi, Galesville	x	x	x
	F. C. Skemp, Fountain City*	a	a	a
Vernon	J. R. Richter, Chaseburg	a	a	a
	Peter Luether, Hillsboro*	x	x	x
Walworth	E. D. Sorenson, Elkhorn	x	x	x
	H. J. Kenney, Delavan*	a	a	x
Washington–Ozaukee	F. I. Bush, West Bend	x	x	x
	T. D. Elbe, Thiensville*	a	a	x
Waukesha	E. C. Van Valin, Sussex	x	x	x
	L. C. J. Olsen, Delafield*	a	x	a
Waupaca	A. M. Christofferson, Waupaca	x	x	x
	F. J. Pfeifer, New London*	a	a	a
Winnebago	B. J. Hughes, Winnebago	x	x	x
	G. R. Anderson, Neenah*	a	a	a
Wood	R. E. Garrison, Wisconsin Rapids	x	x	x
	F. X. Pomainville, Wisconsin Rapids*	a	a	a
Section on Internal Medicine	F. L. Weston, Madison	x	x	x
	F. W. Madison, Milwaukee*	x	a	a
Section on Ophthalmology and Otolaryngology	L. A. Copps, Marshfield	x	x	x
	H. J. Cannon, Milwaukee*	a	a	a
Section on Orthopedics	P. J. Collopy, Milwaukee	a	x	a
	J. E. Miller, Madison*	a	a	a
Section on Radiology	L. V. Littig, Madison	a	a	a
	W. T. Clark, Janesville*	x	x	x
Section on Pediatrics	M. G. Peterman, Milwaukee	x	a	x
	L. M. Simonson, Sheboygan*	x	x	a
Section on Surgery	P. A. Midelfart, Eau Claire	x	x	x

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Society Proceedings

Ashland—Bayfield—Iron

Meeting at the Menard Hotel in Ashland, members of the Ashland–Bayfield–Iron County Medical Society heard a talk by Dr. L. R. Gowan of Duluth, Minn., on October 26. Doctor Gowan spoke on "Psychiatric Aspects and Hints for General Practice." At the business session a medical section for civilian defense was formed, with *Dr. F. D. Weeks* of Ashland as its head. *Dr. J. W. Prentice*, Ashland, delegate to the State Medical Society, reported on the proceedings of the House of Delegates during its October meeting in Milwaukee.

Brown—Kewaunee—Door

Two Milwaukee physicians were guest speakers at a dinner meeting of the Brown-Kewaunee–Door County Medical Society at the Chatterbox in DePere on November 9. *Dr. D. A. Gutheil* spoke on "Differential Diagnosis of Infectious Diseases of the Lung," and *Dr. Mischa J. Lustok* discussed "Differential Diagnosis of Vascular and Neoplastic Diseases of the Lungs." The speakers were sponsored by the American College of Chest Physicians.

Crawford

Dr. H. L. Shapiro, Prairie du Chien, served as host to the Crawford County Medical Society for its November 16 meeting.

Douglas

Dr. M. M. Lavine, Superior, was elected president of the Douglas County Medical Society at its October meeting. He succeeds *Dr. Joseph H. Weisberg*. *Dr. James Easton* was named vice-president, and *Dr. Ralph Anderson*, secretary–treasurer. Both are from Superior. Named to the county advisory board were *Drs. Charles Giesen, C. J. Picard, L. W. Beebe, R. C. Jackson*, and *M. M. Lavine*. *Drs. J. H. Weisberg, R. P. Fruehauf*, and *Conrad Giesen* will serve as the board of censors.

Eau Claire—Dunn—Pepin

Dr. Andrew J. Leemhuis, Minneapolis neurologist, spoke to members of the Eau Claire–Dunn–Pepin County Medical Society on November 27 at the Hotel Eau Claire in Eau Claire. Doctor Leemhuis discussed "Clinical Application of the Electronencephalogram to General Practice."

Kenosha

Dr. Donald F. Kozoll, research associate at Cook County Hospital, Chicago, was the guest speaker at a meeting of the Kenosha County Medical Society on November 2. He discussed the "Surgical Aspects of Jaundice."

Fond du Lac

F. J. CERNY

discussed the "Office Diagnosis of Common Neurologic Problems," and the subject was discussed by *Drs. John Connell* and *A. M. Hutter*. The "Differential Diagnosis of Jaun-

Members of the Fond du Lac County Medical Society met at Schreiner's Restaurant in Fond du Lac on October 26 to hear scientific discussions by physicians from their own group. *Dr. F. J. Cerny* dice" was the title of a presentation by *Dr. E. W. Vetter*. *Dr. J. C. Devine* was the discussant.

Racine

The annual election of officers was the main order of business for the Racine County Medical Society on November 16, when it met at the Racine Country Club. *Dr. G. N. Gillett* will serve as president for the coming year, succeeding *Dr. Beatrice Jones*, Serving with Doctor Gillett will be *Drs. John Albino*, president-elect; *K. W. Covell*, vice-president; and *John Jamieson*, secretary; all are from Racine. *Drs. Gordon Schulz*, Union Grove, and *E. J. Schneller*, Racine, were elected delegates to the State Medical Society, with *Drs. Carl O. Schaefer* and *R. J. Schacht*, both of Racine, as their alternates. *Drs. Louis Fazen, Jr.*, and *Louis Kurten* of Racine were named to the executive board and *Dr. Joseph Dockery*, Franksville, was elected to serve on the board of censors. Guest speaker for the meeting was *Dr. Gorton Ritchie*, pathologist at Columbia Hospital and Milwaukee Children's Hospital, who discussed "Tumors in Children."

Trempealeau—Jackson—Buffalo

Meeting at the Fountain Hotel in Fountain City on November 16, members of the Trempealeau–Jackson–Buffalo County Medical Society heard a talk by Dr. C. W. Rogers, pediatrician on the staff of the Winona Clinic, Winona, Minn. Doctor Rogers spoke on "Infant Feeding."

On October 19 the group met at the Arcadia Golf Club in Arcadia. Guest speakers were *Drs. E. R. Schmidt*, professor of surgery at the University of Wisconsin Medical School, and *Harold M. Coon*, superintendent of the State of Wisconsin General Hospital.

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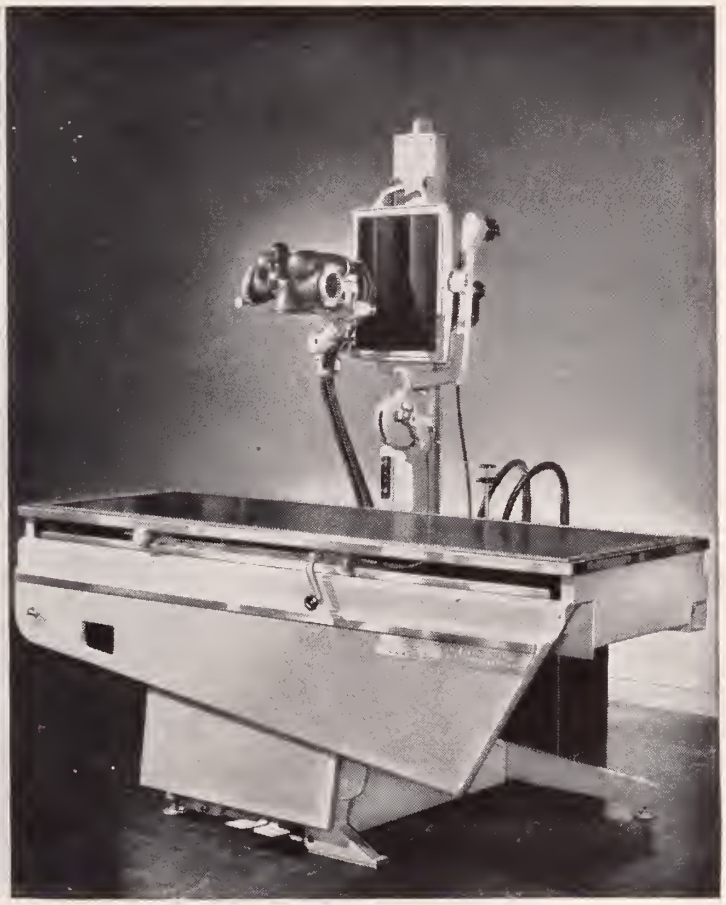

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Winnebago

S. A. M. JOHNSON

Dr. Sture A. M. Johnson, professor of dermatology at the University of Wisconsin Medical School, was the principal speaker at a meeting of the Winnebago County Medical Society held at the Hotel Athearn, Oshkosh, on November 2. His subject was "Common Dermatological Problems."

Ninth Councilor District

Physicians from the Ninth Councilor District of the State Medical Society met at Marshfield on November 9 for a symposium on bronchial asthma by staff members of the Marshfield Clinic and a scientific program following a dinner at St. Joseph's Hospital. Speakers at the evening meeting were *Dr. John S. Hirschboeck*, dean of Marquette University School of Medicine, and Dr. N. J. Helland, urologist at Marshfield Clinic. Doctor Hirschboeck discussed "ACTH, Cortisone, and Other New Drugs," and Doctor Helland presented a paper on "Bladder Obstructions." Participants in the symposium on bronchial asthma, which took place during the afternoon, were *Dr. G. S. Custer*, discussing differential diagnosis; *Dr. J. B. Miale*, pathologic physiology; Beatrice Paulson, R. N., skin testing and results; *Dr. Stephan Epstein*, interpretation of skin tests and hyposensitization; Dr. F. A. Wierzbinski, the ENT aspect; *Dr. J. S. Vedder*, pediatric asthma; and *Dr. F. J. Gouze*, treatment. A question and answer period followed.

American Academy of General Practice, Wisconsin Chapter

A two day convention of the Wisconsin chapter of the American Academy of General Practice was held at the Hotel Loraine in Madison, November 7 and 8. Dr. U. R. Bryner, Salt Lake City, Utah, was the guest speaker at the dinner concluding the meeting, and he urged continuation of the fight against socialized medicine and described the disastrous effects of the British medical program in a talk entitled "General Practice in Socialized England." Doctor Bryner was one of five physicians sent to England by the American Medical Association to study medical conditions.

The convention opened with business sessions on Tuesday, and a scientific program was presented on Wednesday, when *Dr. W. S. Middleton*, dean of the University of Wisconsin Medical School presented the welcome address. *Dr. K. A. Lemmer*, Madison, discussed "Common Errors in Surgery;" *Dr. E. S. Gordon*, Madison, spoke on "What's New in Diabetes"; *Dr. H. M. Suckle*, Madison, presented a paper on "Management of Head Injuries"; and Dr. Charles Slocumb, Rochester, Minn., talked on the "Present Status of Cortisone." Following a luncheon, *Dr. Thomas Geppert*, Madison, spoke on "Newer Concepts in Treatment of Pediatric Conditions"; *Dr. Donald C. Ausman*, Milwaukee presented the question, "What's Happening to General Practice in Wisconsin?"; *Dr. John Hirschboeck*, Milwaukee, spoke on "Infectious Mononucleosis"; and Dr. Walter J. Reich, Chicago, concluded the scientific program with a discussion of "Office Gynecology."

Installed as president of the Academy at the dinner meeting on Wednesday evening was *Dr. Ervin L. Bernhart*, Milwaukee. Serving with him will be *Dr. E. C. Cary*, Reedsville, president-elect; and *Dr. W. B. Hildebrand*, Menasha, secretary-treasurer. *Dr. Charles Giesen*, Superior, was named delegate to the national Academy, and *Drs. C. C. Gascoigne*, Kohler, and *George L. Boyd*, Kaukauna, were elected to the board of directors.

American Academy of General Practice, Manitowoc County Chapter

Dr. Edward Bachhuber, assistant dean of Marquette University School of Medicine, was the guest speaker at the November meeting of the Manitowoc chapter of the American Academy of General Practice, held at the Hotel Manitowoc in Manitowoc. His subject was "Liver Function Tests as an Aid in the Surgery of Jaundice." Guests at the meeting were *Drs. John Minahan* and *J. W. Goggins* of Chilton.

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News Items and Personals

Winnebago—Outagamie County Doctors Guests of Pharmaceutical House

A group of physicians and their wives from the Winnebago-Outagamie County area were guests of Eli Lilly and Company at Indianapolis, Ind., October 8–11. During their visit they inspected the laboratories, including the research laboratories, the replica of the original laboratories, and the biological laboratories at Greenfield, Ind., where demonstrations were made showing the production of biologic products. A photograph taken during their visit appears below.

American College of Surgeons Lists New Wisconsin Members

Nineteen Wisconsin physicians were initiated as fellows in the American College of Surgeons at its thirty-sixth annual clinical congress in Boston during October. These included *Drs. Harold W. Bruskewitz*, Madison; *Florence A. Duckering*, Sheboygan; *John Erbes*, Milwaukee; *Victor S. Falk*, Edgerton; *Louis D. Graber*, Oshkosh; *Harvey K. Guth*, Fond du Lac; *Paul F. Hausmann*, Milwaukee; *B. Jack Longley*, Waukesha; *John T. Mendenhall*, Madison; *James W. Nellen*, Green Bay; *Shimpei Sakaguchi*, Milwaukee; *Russell P. Sinaiko*, Madison; *John R. Steeper*, Madison; *Henry M. Suckle*, Madison; *Donald S. Thatcher*, Milwaukee; *George R. Thuerer*, Rhinelander; *Leo R. Weinshel*, Milwaukee; *William C. Wojta*, Fond du Lac; and *William P. Young*, Madison.

Pathologist Appointed at Luther Hospital

Dr. Richard A. Durham, formerly of Norwich, Conn., was recently appointed pathologist for Luther Hospital, Eau Claire. Certified by the American Board of Pathology, Doctor Durham received his M.D. degree from the Medical College of the State of South Carolina, South Carolina. Following completion of a residency in 1949 he was clinical assistant in pathology at Hartford Hospital and pathologist at William W. Backus Hospital, Norwich, Conn.

Eli Lilly and Company was host to the following Winnebago area physicians and their wives at Indianapolis in October: (left to right) front row—Mr. R. Kniss, Mrs. A. Gloss, Dr. Carl Neidhold, Mrs. Carl Neidhold, Dr. H. Beglinger, Dr. M. Swanton, Mrs. L. McBain, Dr. L. McBain, Dr. G. Lynch, back row—Dr. A. Gloss, Dr. A. Koehler, Mrs. M. Swanton, Mrs. E. Pfefferkorn, Dr. E. Pfefferkorn, Mrs. A. Koehler, Mrs. R. Bitter, and Dr. R. Bitter.

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ENDOCRINOLOGY

Dr. H. Marvin Pollard, Ann Arbor, Mich.
GASTROENTEROLOGY

Dr. John L. McKelvey, Minneapolis, Minn.
GYNECOLOGY

Dr. Arlie R. Barnes, Rochester, Minn.
MEDICINE

Dr. Cornelius P. Rhoads, New York, N. Y.
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Doctor Epstein Heads Dermatology Society

Dr. Stephan Epstein, head of the department of dermatology at the Marshfield Clinic and chief of staff at St. Joseph's Hospital, Marshfield, was recently elected president of the Minnesota Dermatological Society. The doctor is an associate professor of dermatology at the University of Minnesota Medical School. Before joining the staff of the Marshfield Clinic in 1936, Doctor Epstein was a member of the University Skin Clinic, Breslau, Germany, for ten years.

Doctor Baumgartner Joins West Bend Clinic Staff

Dr. James F. Baumgartner, West Bend, recently became associated with the General Clinic in that city. Doctor Baumgartner, who has practiced in West Bend since July 1949, is a graduate of Marquette University School of Medicine.

Oshkosh Physician Heads Red Cross Chapter

Dr. L. D. Graber, Oshkosh physician, was named chairman of the Oshkosh chapter of the American Red Cross at a meeting on November 9. The doctor, a veteran of World War II, began practice at Oshkosh two years ago.

Superior Hospital Names Staff Officers

Dr. J. H. Weisberg, Superior, was named president of the medical staff of St. Joseph's Hospital in that city on November 9. He succeeds *Dr. J. W. McGill*. Others elected were *Drs. H. A. Sincock*, vice-president; and *R. C. Jackson*, secretary. Both are from Superior.

Strum Physician Addresses Welfare Organization

Dr. Earl W. Henry, Strum, addressed the annual dinner meeting of the Family Service Association of Eau Claire on October 24. Doctor Henry, vice-president of the Eau Claire district of the Wisconsin Welfare Council, discussed "The Sick Person in a Sick Community." He has practiced in Strum for four years.

Seymour Physician Elected to International College of Surgeons

Dr. Vernon J. Hittner, Seymour, was elected a diplomate of the International Board of Surgery and a fellow in the International College of Surgeons at a meeting held in Cleveland, Ohio, early in November. Doctor Hittner owns the Hittner Clinic in Seymour.

Dr. C. F. Dull Appointed Local Railway Surgeon

Dr. C. F. Dull, Richland Center, was recently appointed railroad surgeon for the Milwaukee Road at Richland Center, to succeed the late *Dr. Gideon Benson*. Doctor Dull located in Richland Center in 1926, following graduation from Rush Medical College.

Shawano Physician Addresses Lay Groups

A. A. CANTWELL

Dr. A. A. Cantwell, Shawano physician, spoke at a meeting of the Shawano Rotary Club on October 23. He discussed the effects of atomic bombing, pointing out that results of the bombing can be reduced if the public is aware of how to act and if there is sufficient warning time.

The doctor also addressed the P.T.A. and Mother's Club at Iola on November 14, when his subject was "Rheumatic Fever."

Port Washington Doctor Named Head of "March of Dimes"

Dr. C. C. Stein, Port Washington, was named director for the 1951 "March of Dimes" in Ozaukee County on November 2. The doctor has served on the advisory committee of the Ozaukee County chapter of the National Foundation for Infantile Paralysis for many years.

Frederic Physician Attends Postgraduate Course

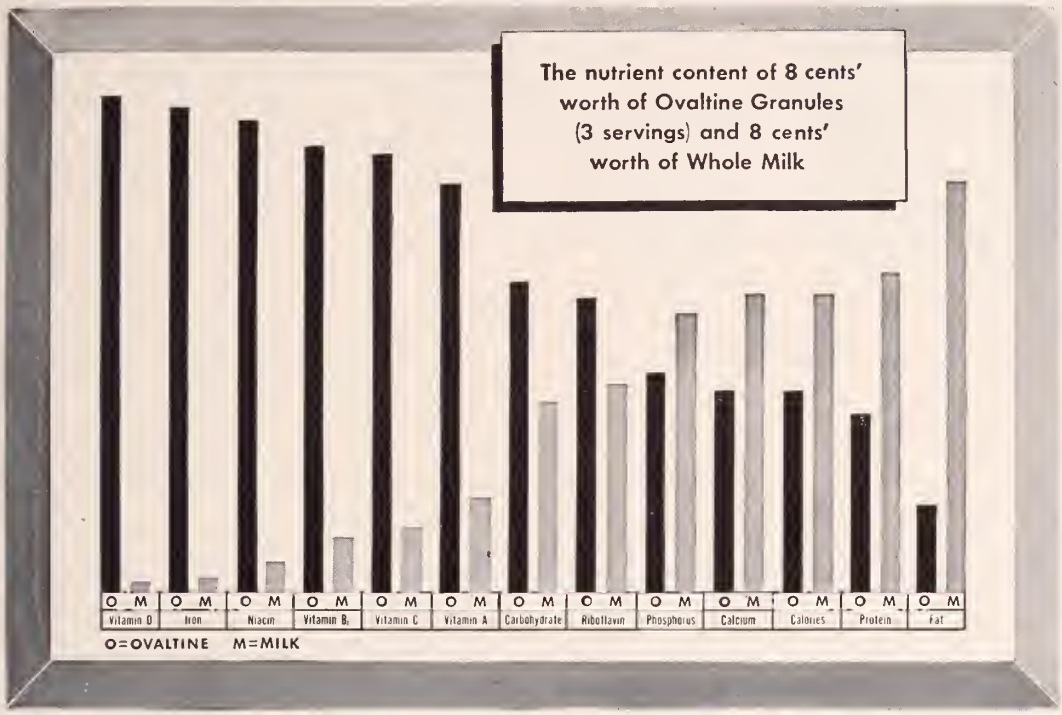
Dr. W. A. Fischer, Frederic, a member of the staff of the Frederic Clinic, attended a course on diseases of the chest at the Center for Continuation Study at the University of Minnesota Medical School, October 26–28. Doctor Fischer has practiced at Frederic since his discharge from the Army Medical Corps in 1946.

Dr. W. F. Enneking Enters Military Service

Dr. W. F. Enneking, formerly in practice in Stevens Point, left in November for service in the United States Navy.

Seven of Twenty Initiates into Fifty Year Club are Graduates of Rush

A recent communication from *Dr. Lewis A. Moore* of Monroe pointed out that that seven of the twenty members initiated into the Fifty Year Club of the State Medical Society in October were graduates of Rush Medical School, class of 1900. These included *Drs. H. H. Kleinpell*, Prairie du Chien; *J. F. Smith*, Wausau; *Hart Beyer*, Pittsville; *F. P. Foley*, Dorchester; *E. T. Rathert*, Chilton; *C. W. Leonard*, Fond du Lac; and *L. A. Moore*.



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—EDITOR'S NOTE

THIRD DISTRICT NEWS

Madison Physician Honored by Surgical Organization

Dr. James A. Jackson, chief of staff of the Jackson Clinic and Methodist Hospital, Madison, was installed as an honorary fellow in the International College of Surgeons at a meeting of that organization in Cleveland on November 3. Doctor Jackson had earlier in the meeting presented a paper on "Surgical Excision of Giant Panniculus Adiposus."

Dr. S. S. Burke Certified by Anesthesiology Board

Dr. Simpson S. Burke, assistant professor of anesthesiology at the University of Wisconsin Medical School, was certified as a diplomate of the American Board of Anesthesiology on October 10. The doctor is president-elect of the Wisconsin State Society of Anesthesiologists and has been appointed to the Committee on Research of the American Society of Anesthesiologists.

Dr. J. W. Brown Appointed Consultant to Naval Research Unit

Dr. John W. Brown, Madison, attended the annual conference of professors of preventive medicine held in conjunction with the annual meeting of the American Public Health Association in St. Louis during October. Doctor Brown has also been appointed consultant to the Naval Medical Research Unit, no. 4 at Great Lakes, Ill., for the purpose of implementing a research project on streptococcic disease, rheumatic fever, and other acute respiratory infections. Drs. Robert Quinn, A. F. Rasmussen, and C. V. Seastone, all of the University staff, are collaborating in this research.

SOCIETY PROCEEDING

Rock

Dr. John E. Gonce, professor of pediatrics at the University of Wisconsin Medical School, Madison, spoke at a meeting of the Rock County Medical Society at the Hotel Monterey in Janesville on November 28. He discussed the "Diagnosis and Treatment of Cystic Fibrosis of the Pancreas." The following doctors were appointed to serve on the Committee on Public Health and Legislation: *Drs. E. W. Reinardy*, chairman; *C. R. Gilbertson; J. C. Springberg; W. C. Sumner; T. L. Vogel;* and *Thomas Flarity. Drs. C. M. Carney*, chairman; *E. R. Otterholt;* and *R. J. Sanderson* comprise the Committee on Cancer Control.

At a meeting on October 24, when *Dr. H. W. Kishpaugh* was named president, *Dr. Vincent W. Koch* closed his year in that position with the following words:

"A year ago I took office as president of the Rock County Medical Society. In prospect, that year seemed a long and difficult term. It has indeed seemed difficult at times, which will not be a novel statement to my predecessors, who have all had momentous and hard decisions to make. However, with the help of the fine officers and committees, and the general membership, those decisions have been met to the best of our ability, and considerable progress in public relations and in other directions has been the result.

"To me, it seems that the welfare of each individual physician or surgeon in Rock County has meant the welfare of the Rock County Medical Society. The Rock County Medical Society, in turn, has meant the welfare of the citizens of this part of the state. We are all inextricably bound up together, and we can no more serve the purposes of one individual without it affecting the interests of everyone else than we can favor one member of the body over another member. This has been my object as president of the Rock County Medical Society—and to all the officers and members who have helped promulgate this purpose, I offer my sincere thanks as I turn over the gavel to my successor—Doctor Kishpaugh. Remember, "Whatsoever thy hand findeth, do it with thy might.' "

TWELFTH DISTRICT NEWS

Milwaukee Physicians Enter Military Service

Two Milwaukee physicians recently entered the United States Armed Forces: *Dr. Donald P. Davis*, formerly a member of the staff of Muirdale Sanitarium, entered the United States Air Force in November. He is located at Fort Dix, N. J. *Dr. Theodore F. Meves* entered the United States Army

on November 16. Doctor Meves reported to Fort Leonardwood, Missouri.

Dr. John T. Hotter, West Allis physician, will begin active duty with the United States Air Force on January 1. He will be stationed at Lochland Air Force Base, San Antonio, Texas.

Dr. H. W. Hefke Appointed to Defense Committee

Dr. Hans W. Hefke, Milwaukee physician, was recently appointed a member of the Radiological Defense Committee of the Milwaukee Metropolitan Civil Defense Commission. Doctor Hefke, associate clinical professor of radiology is head of the department of radiology at Milwaukee Hospital and Milwaukee Children's Hospital.

Model Community Survey Plan to be Tested in Milwaukee

A pilot test of some of the schedules included in the model community survey of available chronic illness services and facilities of the Commission on Chronic Illness will be made in Milwaukee through the cooperation of the Central Service for Chronically Ill. Schedules to be tested in Milwaukee are those covering services to the chronically ill available through rehabilitation services and outpatient clinics. The schedules that obtain information about health education programs in the community for both professional people and the general public may also be tested in Milwaukee. Schedules covering the other aspects of a comprehensive community survey of chronic illness included in the plan will be tested later.

The model survey plan, when tests are complete, will be made available by the Commission on Chronic Illness to communities wishing to measure their existing facilities and services for the care of the chronically ill and the prevention and control of chronic illness.

Dr. J. L. Marks Addresses Society of Engineers

Dr. Jerome L. Marks, Milwaukee physician, addressed a meeting of the Society for Nondestructive Testing in Milwaukee on November 14. The society is composed of engineers and physicists in the Milwaukee area. Doctor Marks, who is a clinical instructor in radiology at Marquette University School of Medicine and director of the department of radiology at the Milwaukee County General Hospital, spoke on new developments in x-ray equipment and diagnosis.

Milwaukee Physician Addresses Jewish Convalescent Group

Dr. Jules D. Levin, Milwaukee surgeon, spoke at a meeting of the men's group and the auxiliary of the Milwaukee Jewish Convalescent Home in Milwaukee on October 31. Doctor Levin spoke on "Strokes and Apoplexy."

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SOCIETY PROCEEDINGS

Milwaukee

Two members of the staff of Marquette University School of Medicine were speakers at a meeting of the Medical Society of Milwaukee County at the Milwaukee Athletic Club on November 10. Dr. William W. Engstrom, assistant professor of medicine, discussed "Thyroid Functions and Thyroid Depressant Drugs," and *Dr. Karl E. Kassowitz*, associate clinical professor of pediatrics, spoke on "The Long Range Effect of Bacteriostatic Therapy on Pneumonia and Allied Diseases."

Milwaukee Academy of Medicine

Dr. Perrin H. Long, Baltimore, was the guest speaker at a meeting of the Milwaukee Academy of Medicine at the University Club of Milwaukee on November 21. Doctor Long, who is a professor of preventine medicine at Johns Hopkins University School of Medicine, spoke about the "Current Clinical Usage of the Antibiotics."

Milwaukee Neuro-Psychiatric Society

Members of the Milwaukee Neuro-Psychiatric Society held a dinner meeting at the University Club of Milwaukee on November 15. *Drs. Saul Pollack* and *R. A. Jefferson* presented reports on the International Congress of Psychiatry in Paris, and *Drs. David Cleveland* and *John Garvey* reported on the meeting of the Central Neuro-Psychiatric Association in Cleveland. All the speakers are from Milwaukee.

Milwaukee Oto-Ophthalmic Society

The staff of the Milwaukee County Hospital presented the program for a meeting of the Milwaukee Oto-Ophthalmic Society at the hospital on November 28. Nasopharyngeal carcinoma was discussed, and cases were presented. ACTH in ophthalmology was another subject presented, with discussions on traumatic amaurosis and the Sturgi–Weber syndrome. The present status of Milwaukee County Hospital was discussed by *Drs. J. C. Sargent* and *W. L. Coffey*.

SOCIETY RECORDS

New Members

Rex Ruppa, 5589 North Bay Ridge Avenue, Milwaukee 11.

L. B. McCabe, 69 East First Street, Fond du Lac.

J. C. Curry, Mount Calvary.

A. L. Rhoades, 1020 University Bay Drive, Shorewood Hills, Madison.

R. K. Irvine, Manawa.

Y. B. Sutch, Lake Geneva.

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A. R. Altenhofen, Wauwatosa, to R. R. 8, Box 277, Milwaukee 13.

M. B. Smith, Wauwatosa, to V. A. Hospital, Minot, South Dakota.

A. B. Grant, Milwaukee, to 610 College Street, Racine.

A. W. Radke, Wauwatosa, to 1901 Hoyt Avenue, Everett, Washington.

R. G. Gallimore, Detroit, to 161 West Wisconsin Avenue, Milwaukee 3.

R. F. Swanson, Whitehall, to Mondovi.

W. E. Clasen, Davenport, Iowa, to 3172 North 50th Street, Milwaukee 10.

R. A. Sundeen, El Monte, California, to 1108 Baldwin Avenue, Arcadia, California.

R. W. Hall, Wauwatosa, to San Francisco City-County Hospital, University of California Service, San Francisco, California.

G. V. Murphy, Wood, to 928 Milwaukee Avenue, South Milwaukee.

E. E. Dockery, Fond du Lac, to Bird Neck Point, Virginia Beach, Virginia.

J. W. Frye, Capt., M.C., Milwaukee, to R.A. 058083, Osaka Army Hospital, Unit 5, A.P.O. 25, San Francisco, California.

Max Baumeister, Jr., Madison to 1403 East Seneca, Tuscon, Arizona.

H. C. Sprecher, Wauwatosa, to 2374 North 54th Street, Milwaukee 10.

H. W. Wood, Jr., Neenah, to Mercy Hospital, Oshkosh.

F. H. Garbisch, Antigo, to 2103 North 59th Street, Milwaukee.

E. F. Schubert, Wauwatosa, to Logansport State Hospital, Logansport, Indiana.

P. J. Trier, Milwaukee, to 6618 Windsor Avenue, Berwyn, Illinois.

G. E. Fox, Wood, to Armed Forces Institute of Pathology, Washington, D.C.

D. E. Wynegar, Knoxville, Iowa, to Cherokee State Hospital, Cherokee, Iowa.

Clarence Samuelson, Milwaukee, to Box 318, Hartland.

W. B. Hobbins, Madison, to Cook County Hospital, Chicago, Illinois.

R. E. Hayes, Fort Benjamin Harrison, Indiana, to 810 South Main Street, Mount Pleasant, Michigan.

J. T. Murphy, Casper, Wyoming, to St. Joseph's Hospital, Mitchell, South Dakota.

R. E. Flood, Milwaukee, to New York Women's Hospital, New York City.

D. L. Dawson, Eau Claire, to Apartment 2, West, 3301 Harvey, Madison.

DEATHS

Dr. Mina Brooks Glasier, a practicing physician at Bloomington for sixty years and an honorary member of the State Medical Society, died at her home in that community on November 16. She was 91 years old.

Doctor Glasier was born near Bloomington on November 5, 1859. She was graduated from Hahnemann Medical College, Chicago, in 1883 and practiced medicine with her husband at Bloomington until his death in 1900. For fourteen years she served on the Wisconsin State Board of Health.

In 1932 Doctor Glasier was presented the Council Award of the State Medical Society, the highest award bestowed by that organization. In 1933 she was made a life member of the Society, and in 1944 honorary membership was accorded her.

For thirty-five years she was secretary of the Grant County Medical Society and at one time she had also served as its president. She was also a member of the American Medical Association.

A daughter survives.

Dr. William H. Bartran, pioneer physician at Green Bay, died at his home in that city on November 20. He was 76 years old.

Doctor Bartran was born on June 23, 1874 at Fort Howard. He received his degree in medicine from Northwestern University Medical School in 1899, and, following internship at St. Luke's Hospital, Chicago, and St. Joseph's Hospital, St. Paul, Minn., returned to practice with his father at Green Bay in 1900. He studied in Europe on two occasions and on return from Germany in 1913 brought back the first x-ray apparatus used in the Green Bay area. In 1913 he established the Fairfield–Bartran Clinic with the late Dr. W. E. Fairfield.

The doctor was a past president of the Brown–Kewaunee–Door County Medical Society and held life membership in the State Medical Society. He also was a member of the American College of Surgeons, American Proctological Society, Radiological Society of North America, and American Medical Association.

He is survived by his wife and two daughters.

Dr. Anton J. Schramel, 44, district health officer for the Fond du Lac area, died suddenly on November 17 at a hospital in Mount Clemens, Mich. He had been in Ann Arbor, Mich., studying for a master's degree in public health at the University of Michigan and was in Mount Clemens for a field course when he became ill.

The doctor was born in Milwaukee. He attended Marquette University School of Medicine, receiving his M. D. degree in 1933. He interned at St. Mary's Hospital, Milwaukee, and at Los Angeles before entering practice in Milwaukee in 1934. From 1940 to 1946 he served with the Army Medical Corps and, following discharge with the rank of major, he

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joined the Milwaukee Health Department as a school physician. He was named deputy health commissioner in 1946. Four years later he became health officer of district 3 of the State Board of Health, stationed at Fond du Lac.

Doctor Schramel was a member of the American Public Health Association, the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by his wife, a daughter, and a son.

Dr. C. R. Cannon, Ellsworth physician for thirty-six years, died suddenly at his home in that community on November 3. He was 59 years old.

The doctor was born at Dale on December 1, 1890. He received his medical degree from Marquette University School of Medicine in 1913, interning at St. Joseph's Hospital in St. Paul. In 1914 he moved to Ellsworth, where he practiced until the time of his death.

Doctor Cannon was a member of the Pierce–St. Croix County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife, two daughters, two sons, and his father.

Dr. Walter C. Frenzel, widely known Wausau physician, died suddenly while visiting at the home of a neighbor on November 26. The doctor, who was 51 years old, was chairman of the executive board of St. Mary's Hospital in Wausau.

A native of Wausau, Doctor Frenzel was born on Jan. 28, 1899. He received his medical degree from the University of Illinois College of Medicine in 1924, locating in Wausau shortly afterward. In 1936 he went to Europe for postgraduate study in surgery at the University of Vienna. He was a member of the surgical board of St. Mary's Hospital and served as Chairman of St. Mary's Nursing School and as instructor in gynecology at that institution.

The doctor was a member of the International College of Surgeons, the Marathon County Medical Society, the State Medical Society, and the American Medical Association.

His wife and a son survive.

Dr. William T. O'Brien, 77, physician at Mauston for half a century, died at his home in Mauston on November 26. He had retired from active practice last summer.

Doctor O'Brien was born in Delona in Sauk County on August 2, 1873. He attended Marquette University School of Medicine, receiving his M. D. degree in 1900. Later that year he established his practice at Mauston.

Survivors include his wife and two daughters.

Dr. Marie Z. Vermeiren, 79, retired Green Bay physician, died at her home near Oconto on November 29. She had practiced medicine at Green Bay for nearly fifty years before her retirement about four years ago.

Doctor Vermeiren was born in Belgium on Nov. 9, 1883. She received her medical degree from Gross Medical College, Denver, Colo., in 1900 and began practice in Green Bay shortly afterward. She retired from her medical work in 1946.

There are no immediate survivors.

Dr. George F. Ronneburger, Cambria physician, died at a Milwaukee hospital on August 14, following an illness of several months. He was 72 years old.

Doctor Ronneburger was born in Germany on Jan. 30, 1878. He received his medical degree from the University of Michigan Medical School in 1902, and remained to practice in Ann Arbor, Mich., for several years. Later he located in Milwaukee, practicing there until 1942, when he moved to Cambria.

He is survived by a son.

Dr. Albert E. Yanke, well known Milwaukee physician, died at his home in Milwaukee on October 7. He was 77 years old.

Doctor Yanke was born on August 1, 1873. He received his medical degree from Northwestern University Medical School, Chicago, in 1898, entering practice in Milwaukee shortly afterward.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

His wife and two daughters survive.

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November 2, 1950

Dear Sir:

It is time for me again to thank you and your State Society for keeping me on your mailing list for the splendid Wisconsin Medical Journal ever since I was president of the State Medical Society. The Journal never fails to charm me and I congratulate you on your great help to the profession.

This particular number earns interest and regret because of the article by my old friend, the late Dr. Arthur Patek. He was one of the kindliest and most impersonal of the great physicians of the middle west of his period. It is strangely fitting that the essay that he wrote on the development of your Journal should have so promptly become his swan song.

Always with good wishes, I am

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(s) E. L. TUOHY, M. D.

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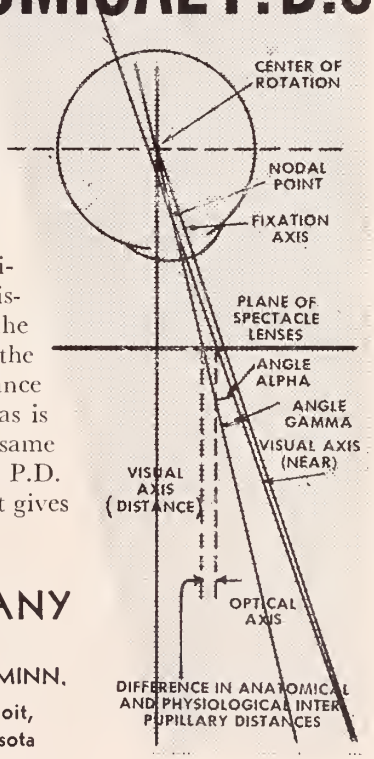

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Clinical Radiation Therapy. Edited by Ernst A. Pohle, M.D., Ph.D., F.A.C.R, Professor of Radiology, Chairman, Department of Radiology, University of Wisconsin Medical School, Madison, Wisconsin. Second edition. Pp. 902, with 201 illustrations and 1 color plate. Philadelphia: Lea & Febiger, 1950. Price $15.00.

The second edition of this book on radiation therapy will be welcomed by those familiar with the earlier volume, published nearly 12 years ago. The book has been extensively revised, much of it rewritten, with the addition of nearly 100 pages and 139 new illustrations. Of value is the inclusion of radium therapy, thus leading to a change of title from "Clinical Roentgen Therapy" to "Clinical Radiation Therapy." The authors, 20 in all, are well known American radiologists and clinicians. The editor and these authors are to be commended for the excellence of presentation and the correlation of a large amount of material covering the entire field of radiation therapy. As in the previous edition, numerous editorial footnotes add to the value of the discussions. An ample bibliography of pertinent references is appended to each chapter, and these have been carefully selected to enhance the discussion for those interested in more detailed reviews of the subject matter. Two new supplements have been added, one dealing with low intensity radium needles and the other giving dosage calculations for radium therapy. The quality of printing is excellent, and a good index has been provided.

To the practicing radiologist as well as to the beginner in radiology this book will serve as an authoritative guide to current practices. It can be recommended likewise to those clinicians who desire information concerning the possibilities and limitations of modern radiation therapy.—L.W.P.

For the New Mother. By Mildred V. Hardcastle, R. N. Philadelphia and Toronto, The John C. Winston Company, 1948. Price $2.00.

This is a charming little book of 159 pages written by an experienced mother and nurse. It contains very practical information about the guidance of normal physical and mental growth. In addition, the author gives the young mother sound advice about her own needs as well as those of her family during the period of adjustment to the new arrival.

Written largely on the basis of her own rich experience, the author has drawn freely from the best of modern thinking about infant growth and development to complete a book which this reviewer believes is a must for the new mother.—K. B. McD.

Fractures and Dislocations in General Practice. By John Hosford, M.S. Lond., F.R.C.S., surgeon to St Bartholomew's Hospital. Second edition revised by W. D. Coltart, M.B., B.S. Lond., F.R.C.S., assistant orthopaedic surgeon to St. Bartholomew's Hospital. With 87 illustrations. New York and London: Paul B. Hoeber, Inc., 1950. Price $5.00.

One can scarcely find fault with the principles of treatment set forth by the authors, or, for that matter, the manner in which they present their views; however, this book falls short of the purpose which may be inferred from the title and which is clearly expressed in the preface to the first edition that ". . . the book will prove of value . . . to the general practitioner who has occasion to treat fractures from time to time . . ." It would seem that the less one's experience, the more encyclopedic his information must be, and although no book, regardless of its proportions, could include or probably need consider all types and variations of traumatic bone and joint conditions; nevertheless, it is felt that the book is not of sufficient scope to guide the general practitioner who must rely upon his personal library for information regarding these conditions which are characteristically of a moderately urgent nature.

But brevity does not go wholly unrewarded, and this book would seem to be ideal for the student who must have a general knowledge of the mechanisms and deformities of fractures and dislocations, and of some of the methods employed in the treatment without the need for immediate application of this knowledge and without the attendant responsibility to a

patient. The early sections relating to diagnosis, healing, and complications are uncommonly good. The book is a little short on illustrations.

We might say that here is a book that is a pleasure to read but for those who would rely solely upon it for technical information we could shamefully parodize,

> Fondly do we hope, and fervently do we pray,
> Just the fractures in the book, are the ones that come their way.

—H. I. O.

Diseases of the Foot. By Emil D. W. Hauser, M S., M.D., Associate Professor of Bone and Joint Surgery, Northwestern University Medical School. Second edition. Pp. 415, with 195 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $7.00.

As I see it, the main weakness of this book is that Doctor Hauser abandons what should be its *raison d'être*—a presentation of the diagnosis and treatment of functional disorders of the foot—to devote fully one half the volume to discussions of diseases and injuries of bones and joints, vessels, nerves, etc., which are not peculiar to the foot but rather include the foot as one of the sites of involvement. Thus he considers at length many conditions which are adequately covered by other authors, with a proportionate neglect of those disorders regarding which he is particularly competent and physicians in general lamentably uninformed.

However, this observation constitutes more a personal opinion as to what a book on diseases of the foot should be concerned with rather than a criticism of the material contained, and the book deserves looking into for its authoritative exposition on the foot in the growing child and the fitting of shoes, and especially on the conservative management of the painfully ambulant, flat-footed patient.

I should prefer to feel that the apparent emphasis on the forceful manipulative treatment of inadequately correctly clubfeet is unintentional.—H. I. O.

Clinical Pathology; Application and Interpretation. By Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, University of Arkansas School of Medicine, Little Rock Arkansas. Pp. 397, with 32 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $6.00.

"Insufficient or improper use of the laboratory is most often an evidence of ignorance; excessive reliance on laboratory results is proof of inexperience" —Wells.

The purpose of this volume is to assemble and reorganize the significant data of clinical pathology and to answer some of the questions confronting the physician in the clinic and at the bedside.

It is not a laboratory manual of methods but rather a book dealing with the application and interpretation of laboratory procedures.

The subject matter is nicely arranged in nine chapters. There is an appendix, prepared with the

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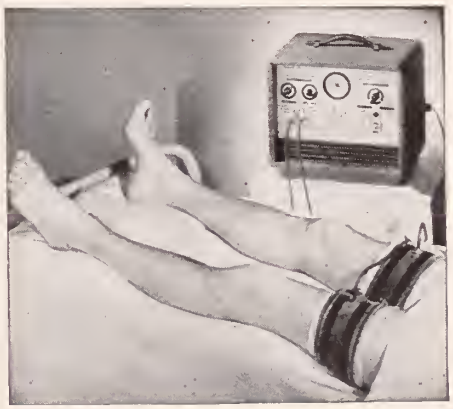

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assistance of Dr. A. E. Moon, which is largely concerned with laboratory aids in symptom diagnosis. There are chapters on infectious diseases, diseases of the gastrointestinal tract, diseases of the respiratory system, diseases of the kidney and urinary tract, diseases of the blood, diseases of the cardiovascular system, metabolic and endocrine disorders, clinical laboratory studies in surgery, and clinical laboratory studies in obstetrics.

The reviewer believes that the author has prepared a very interesting and informative book and has done well in keeping it within the limits of less than 400 pages. Interns and advanced medical students should be urged to make it a part of their library.—W.H.J.

Quinidine in Disorders of the Heart. By Harry Gold, M. D., Professor of Clinical Pharmacology at Cornell University Medical College, Attending in Charge of the Cardiovascular Research Unit at the Beth Israel Hospital, Attending Cardiologist at the Hospital for Joint Diseases, Managing Editor of the Cornell Conferences on Therapy. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper and Brothers, 1950. Price $2.00.

In this monograph Doctor Gold has presented in very readable form what the clinician should know about quinidine. The indications, therapeutic actions, toxic actions and dosage in such arrhythmias as paroxysmal tachycardia, auricular flutter, auricular fibrillation, and ventricular fibrillation are discussed in a very clear and comprehensive manner. The basic pharmacologic action of quinidine is described in detail and repeatedly emphasized in such a way as to clarify the rationale of its use and manner of administration under various clinical conditions. Case histories from the actual experience of the author have been used judiciously to illustrate the practical application of the principles discussed and also add greatly to the general interest. The controversial subject of the combined use of digitalis and quinidine is well handled. It is unfortunate that the chapter on "preparations of quinidine" omitted all mention of quinidine gluconate, which gives promise of materially widening the usefulness of this alkaloid. In the opinion of the reviewer, too many physicians are afraid to use quinidine and frequently withhold it when it is clearly indicated. Others use it, but with a considerable degree of uncertainty. Doctor Gold's handy little volume clears the atmosphere on the entire subject of the use of this important drug and should prove of distinct practical value to all physsicians, general practitioners and specialists alike, who are called upon to treat patients with cardiac disorders.—C.M.K.

The Medical Clinics of North America. Massachusetts General Hospital Number. Philadelphia and London, W. B. Saunders Company, 1949.

The section of this volume containing the symposium on recent advances in medicine presents an excellent summary of problems of thyroid disease, with emphasis on diagnosis and treatment of toxic goiter with radioactive iodine. Of more widely applicable value perhaps are the articles dealing with treatment of auricular flutter, hypertension, and degenerative joint disease. Among the several additional articles appearing from various sources, the one on diagnosis and treatment of headache should receive particular mention.—E.C.A.

Handbook of Digestive Diseases. By John L. Kantor, M. D., F. A. C. P., late associate in medicine, Columbia University; gastroenterologist and associate roentgenologist, Montefiore Hospital, New York; and Anthony M. Kasich, M. D., F. A. C. P., lecturer in medicine, Columbia University; adjunct physician, Montefiore Hospital; assistant visiting physician, Bellevue Hospital; assistant adjunct gastroenterologist, Lenox Hill Hospital, New York. Second edition. St. Louis: The C. V. Mosby Company, 1949. Price $11.00.

This is a successor to Kantor's "Synopsis of Digestive Diseases." It appears, therefore, under a new title, "Handbook of Digestive Diseases." although it is published as a second edition of the "Synopsis." Kasich has retained most of Kantor's original contribution, but he has added so much in bringing the book up to date one would scarcely recognize it as the successor to the first edition. This second edition, increased so much in size, reflects not so much changed authorship as the great increase in our knowledge of gastroenterology. The book consequently serves a much more useful purpose than the now outdated "Synopsis."

The most striking characteristic of this book is its practical, clinical usefulness, especially to the general practitioner and to the student. In addition to a conciseness and lucidity of expression, the book is profusely illustrated with charts, diagrams, photographic, and x-ray reproductions to enhance its usefulness. Printde on a high grade of gloss paper, the microscopic and gross photographic illustrations are especially good.

If that which is of didactic interest is missing, it should be found by reference to a comprehensive list of references at the end of each chapter.

This book is to be recommended for what it was intended to be: a handbook and not an extensive treatise of gastro-enterology.—K. L. P.

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PHYSICIAN WANTED: With good surgical training as an assistant and later as a partner, to do all surgery in a well-established general practice in north central Wisconsin, excellent hospital, city of 10,000. Salary the first year; partnership after that. Give full qualifications and personal history. Address replies to No. 334 in care of the Journal.

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WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service. Salary depends upon previous experience and training. Contact Dr. W. J. Urben, Superintendent, Mendota State Hospital, Madison, Wisconsin.

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WANTED: Physician for downtown Milwaukee office. Temporary for month of February 1951. Full time. Mostly industrial. Good salary. Address replies to No. 345 in care of the Journal.

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FOR SALE: Practice and equipment of deceased physician, together with well established clinic and medical center in eastern Wisconsin city. Excellent opportunity. Address replies to No. 341 in care of the Journal.

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FOR SALE: Electrocardiograph, Beck Lee, model E. Address replies to M. Margoles, 1346 North Twelfth Street, Milwaukee 5, Wisconsin. Phone Marquette 8-2202.

WANTED TO BUY: Complete office equipment in good condition, old or new, including desk, chairs, laboratory equipment and instruments. E. G. Nafziger, M. D., Oxford, Wisconsin. Phone 24.

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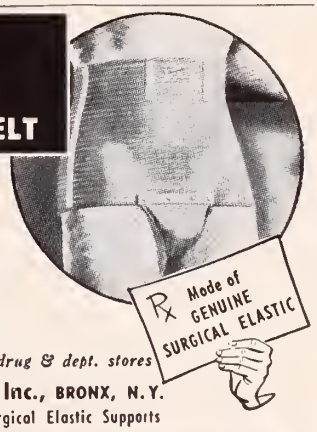

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